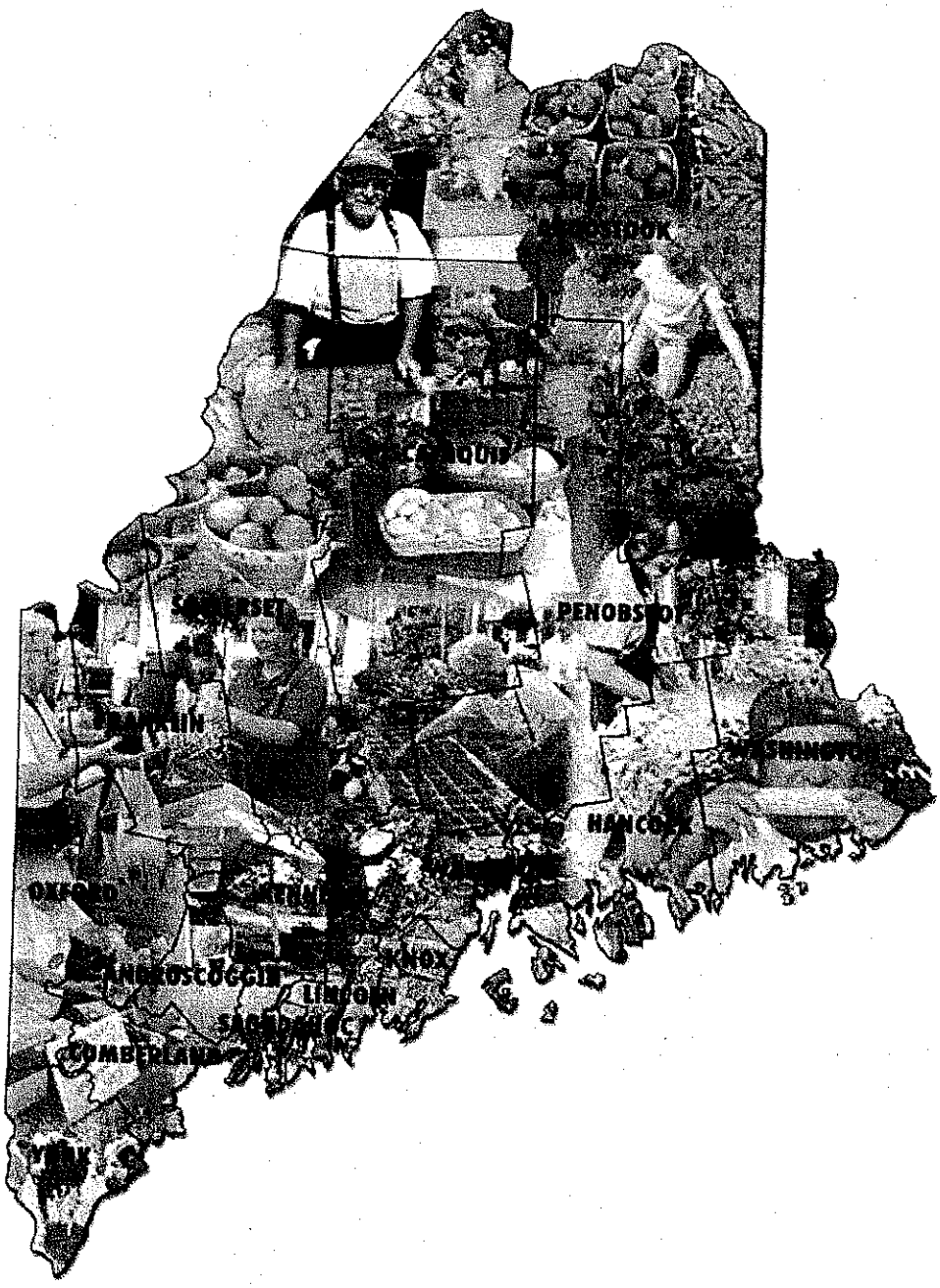
Statewide Quality Improvement Council

Orientation Book



June 2006

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2006
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STATEWIDE QIC

Statewide Quality Improvement Council

Greetings and Welcome to the QIC!

It gives me great pleasure to welcome you as a new member of the Statewide Quality Improvement Council. As you will discover, the QIC is comprised of a diverse group of individuals, representing equally diverse perspectives. You will also discover that Council membership includes those who are longstanding members, relatively new members and others, like yourself, who are new to the work of the Council. As a new member, I want to encourage you to 'jump right in and get your feet wet'. You bring a perspective to the Council that we believe will enrich and further our goals and the work we undertake. We need and want your input and participation at meetings. I encourage you to become a member of sub-committees, to volunteer to represent the Council at meetings or events and to bring relevant information to the attention of the Council.

As the Mental Health Planning Council required by the Federal Mental Health Block Grant funding agency, we have a unique role. While the work of the Council can be both engaging and procedural, its primary focus remains constant: making recommendations and serving in an advisory capacity to the Maine Department of Health and Human Services, Adult Mental Health Services and Children's Behavioral Health Services to improve the system of care for adults with a serious mental illness and children with a serious emotional disturbance.

This core group of individuals that makes up the Council has its work cut out for itself. We have a steep learning curve ahead of us as we learn about, absorb, question and advise the Department on a variety of topics including: managed care, fiscal concerns, transforming the delivery of services in Maine and the integration of services into the larger entity of the Department of Health and Human Services. Our role is evolving as we work together to assume a larger quality improvement role. We stand poised to impact significantly on changes as they are recommended. I want to stress again how important your input and expertise is to this process and how pleased I am that you have joined us.

Welcome to the Council!

Margaret

Margaret S. Degon, Chair
Statewide Quality Improvement Council

Statewide QIC Calendar Jan 2006 - December 2006

Block Grant Tasks	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06
Review Block Grant Submission							7th					
Review Block Grant Submission								10th				
Submit Letter of Support								28th				
Submit Block Grant Application to CMHS								31st				
Chair and State Rep Attend BG Review										17th		
Submit Letter of Support for Block Grant Implementation Report											27th	
Submit Block Grant Implementation Report to CMHS											30th	
Begin Planning Re Block Grant Public Comment	6th											
Block Grant Training Conference in Wash D.C.				May 29-Jun 2,2006								
Statewide QIC Meeting	6th	3rd	3rd	7th	5th	13th	7th	10th	1st	6th	3rd	1st
DIG Tasks												
Dig Steering Committee Meetings			28th			27th			26th			26th
DIG Presentations on 2005 Data		3rd		7th			7th			6th		
*Note Proposed Meeting Change												

Statewide QIC BY-LAWS

Article I
Name and Area

Section 1 **Name:** The name of this organization shall be the Statewide Quality Improvement Council, otherwise known as the Statewide QIC, also referenced in these by-laws as "the council".

Section 2 **Area:** The Statewide QIC defines its area of geographic coverage to include all counties within the State of Maine.

Article II
Purposes and Definitions

Section 1: **Vision:** To ensure that all people served by the Department of Health and Human Services in the State of Maine might proclaim Maine as providing the nation's highest standard for quality services in an environment of respect and empowerment.

Section 2: **Mission:** The mission of the Statewide Quality Improvement Council is to:

- Advise the Commissioner on issues of system implementation that have statewide impact (Maine Public Law (1995), Chapter 691)
- Serve as the mandated advisory board for purposes of advising the Department relative to the federal Community Mental Health Block Grant (Federal Public Law 102-321)

Section 3: **Values:** The Statewide QIC supports the following values:

- Fair and open participation by all Members, encouraging the empowerment of consumers and family members, is necessary for valid work to be accomplished
- Fostering education of its members and the community at large is important to the advancement of the Council's mission
- True collaboration thrives in an environment of diversity, candor, respect and trust
- The process of inclusive stakeholder participation will build consensus and understanding of divergent perspectives.

Section 4: **Compliance with State Law:** Nothing herein shall authorize the council directly or indirectly to engage in or include among its purposes any of the activities prohibited by State law.

Section 5: **Definition of Terms:** For purposes of these by-laws, the following terms are defined:

- Commissioner: the Commissioner of the Department of Health and Human Services
- Department: The Department of Health and Human Services
- Community Members: persons who represent the composition of the community at large.
- Consumer: a recipient or former recipient of behavioral or developmental services
- Family Member: a parent, relative, guardian or household member of a consumer
- Quality Improvement Council (QIC): those local and institutional QICs established in accordance with PL 691 as cited in Article 2, Section 2 of these by laws

Article III
Fiscal Year

The fiscal year of the Council shall be July 1 through June 30.

Article IV
Parliamentary Authority

The current edition of Robert's Rules of Order shall be the final source of authority in all questions of parliamentary procedure when such rules are not inconsistent with the by-laws of the Council.

Article V
Membership of the Council

Section 1: **Composition:** The Council aspires to have its membership be representative of the Various components of the community served by the Department. Consequently, 51% of the membership of the Council shall be composed of consumers and family members in order to benefit from the skills, insight, perspective and guidance of these constituents. Membership will be offered to a designee from each of the nine QICs and to members at large recommended by the State QIC and appointed by the Commissioner. Membership shall consist of a minimum of 15 (fifteen) and a maximum of 25 (twenty-five) members.

Section 2: **Powers and Duties:** The powers and duties of the Members of the Council shall be:

(a) to discuss issues and make recommendations relating to the services impacting the lives of people served by the Department;

(b) to formulate and adopt by-laws and meeting procedures consistent with the Mission and Values of the Council;

(c) to be responsible for budgeting and authorizing expenditure of funds allocated to the Council in a manner consistent with governing policies and law;

(d) to serve as the Advisory Council to the Department for purposes of participating in the development and review of the application for the Community Mental Health Services Block Grant;

(e) to approve appointments of all Committee Chairs and the establishment of new committees not provided for in the by-laws;

(f) to elect officers of the Council;

(g) to perform such other duties as may from time to time arise in order to further the purposes of the Council.

Section 3: **Term:** The initial term of each member at large of the Council shall be for on (1) year. Subsequent terms may be for two (2) years or three (3) years in order to effect staggered terms. No member of the Council shall serve more than four (4) consecutive terms or ten (10) consecutive years. He/she shall be eligible for reappointment after an interval of one (1) year. The Vice Chair of the Council may have his/her term extended past the ten (10) year limit to allow a Vice Chair to succeed as Chair of the Council if so elected. The immediate past Chair of the Council shall be given a one-year, ex officio term with the right to vote if the immediate past Chair's term has expired. An individual member of the Council may have his/her term extended by

up to a three (3) year term if so voted by a two thirds (2/3) vote of the entire Council membership.

Section 4: **Vacancies:** The Council shall notify the Commissioner of member at large vacancies as they occur and may make recommendations of persons for nomination or organizations or entities to be represented.

Section 5: **Regular Meetings:** The Council shall meet on a monthly basis, no fewer than ten (10) times a year, at a time and place determined by the Chair with written notice to the members at least five days prior to the meeting.

Section 6: **Special Meetings:** special meetings of the Council may be called by the Chair, Vice Chair or any three (3) Members upon 24 hours notice. If all Council Members sign a waiver of notice to any special meeting, then actions taken thereat shall be proper even though no notice was given. Such signed waivers shall become a part of the minutes of that meeting.

Section 7: **Location of Meetings:** The Council may hold its meetings in such place or places as the Council may, from time to time, determine. In all instances handicap accessibility shall be accommodated within the guidelines of the law.

Section 8: **Quorum:** At any meeting of the Council a quorum shall consist of a simple majority of the council and vote of those present, if there is a quorum, shall constitute the act of the Council unless otherwise stated in these by-laws or State law.

Section 9: **Voting:** In addition to voting when present at a meeting, if a quorum of the Council deems necessary on any specific motion, a Member of the Council may cast her/her vote by phone, FAX or e-mail. In these cases, a statement signed by the Member so voting should be obtained as soon as is reasonable and attached to the minutes of the appropriate meeting.

Section 10: **Attendance:** Any Council member with three (3) consecutive unexcused absences shall be considered to have resigned from the Council. Notification to the Department or the Council Chair prior to the Council meeting shall constitute an excused absence. Because of the need to have an informed and active Council, any member who misses four or more meetings in a fiscal year whether excused or unexcused shall be asked by the chair if he or she continues to be interested in and able to serve at the current time. The Chair may then call for a vote of the Council to offer a recommendation to the Commissioner, if the member is a member at large, or to the represented QIC regarding the individual's tenancy on the Council.

Section 11: **Conflict of Interest:** Upon joining the Council and annually thereafter, each Member shall complete a disclosure form. The Members will not use their position to profit personally from the work of or as a result of decisions of the council.

Article VI
Officers

Section 1: **Officers:** The officers of the Council shall be a Chair, Vice Chair, Secretary and Treasurer. The Chair, Vice Chair, Secretary and Treasurer shall be elected by and from the members of the Council upon recommendation of the Membership Committee and shall hold office for two (2) years. Terms shall coincide

with the State's fiscal year. Vacancies in any office shall be filled by the Council for the unexpired term upon recommendation of the Membership Committee.

Section 2: **Chair:** The Chair shall, subject to the instruction of the Council, exercise leadership in the successful fulfillment of the mission of this council. The Chair shall preside at all meetings of the Council and the Executive Committee; shall appoint the Committee chairs and be an ex officio member of all committees with the right to vote on all matters before the committees; shall call special meetings as necessary; and shall perform all duties incidental to the office.

Section 3: **Vice Chair:** In case of the absence of the Chair, the Vice Chair shall perform the duties and execute all of the powers of the Chair. The Vice Chair shall do and perform such other acts as the council may, from time to time, authorize her/him to do. Should the Chair's office be vacated, the Vice Chair shall become Chair for the remainder of the term.

Section 4: **Secretary:** The Secretary shall record or cause to be recorded all votes and minutes of all proceedings of the Council and the Executive committee in a book to be kept for the purpose. Additionally, the Secretary shall review all minutes of the Council prior to distribution to the membership for approval.

Section 5: **Treasurer:** The Treasurer shall maintain the records or see to their maintenance in such fashion as to give an accurate accounting of the financial transactions of the Council. He/she shall render or see to the rendering of such reports as the Council may require. The Treasurer shall normally be a member of the Budget Committee. The Treasurer shall perform, in addition, such other duties as may be delegated by the Council.

Article VII
Committees

Section 1: **Executive Committee:** The Executive Committee shall consist of the Officers of the Council and may include the immediate past Chair of the Council.

(a) When matters of urgency arise, the Committee shall have the authority to conduct the business of the Council in intervals between meetings. The Executive Committee shall keep and distribute to the Council regular minutes of its proceedings, report its actions, and seek ratification of any actions at the next meeting of the Council.

(b) A quorum shall be a majority of the Executive Committee's membership.

Section 2: **Standing Committees:** The Chair, with the advice and consent of the Council shall appoint annually the chairs of all standing committees. Together the Chair and the Committee Chairs shall name the committee members. Committee Chairs shall be responsible to the Council for the function and duties of the committees. Committee Chairs shall be members of the Council. However, membership to committees may be extended to individuals, not serving as members of the Council, whose participation will enhance the integrity and quality of deliberations. Such committee members may or may not be voting members of the committee on which they serve depending upon the determination of the Council.

(a) The **Planning Committee** develops an annual plan for consideration and adoption by the Council. The Committee is responsible to monitor the implementation of the plan. Furthermore, the Committee may make recommendations as to the content of the Council's agendas based upon the Committee's work.

(b) The **Budget Committee** develops and oversees the budget and budgetary process, reviews and makes recommendations to the Council as to the management and maintenance of the Council's assets.

(c) The **Adult Services Committee** makes recommendations to the Council regarding the allocation and adequacy of adult mental health services in the State. Additionally, the Committee shall participate in the development and review of the adult portion of the Community Mental health Services Block Grant plan.

(d) The **Children's Services Committee** makes recommendations to the Council regarding the allocation and adequacy of children's mental health services in the State. Additionally, the Committee shall participate in the development and review of the children's portion of the Community Mental Health Services Block Grant plan.

(e) The **Membership Committee** reviews and makes recommendations to the Council as to adequate and appropriate representation and participation of the Council's membership in order to fulfill the mission and uphold the values of the council. The review would include consideration of compliance with basic requirements of the CMHS Block grant.

Section 3: **Ad Hoc Committees:** Shall be appointed as necessary by the President with the advice and consent of the Council.

Article VIII
Nondiscrimination

The members, officers, and committee members shall be selected entirely on a non-discriminatory basis with respect to age, race, gender, religion, sexual orientation or national origin.

Article IX
Amendment

These by-laws may be amended or altered, not inconsistent with the laws of this State, by a two-third (2/3) vote of the Council. Notice of the meetings to make any changes in the by-laws shall include proposals for changes and be submitted in writing to the Council at least ten (10) days prior to the meeting at which they are to be acted upon.

Adopted: June 6, 1997
Revised May 3, 2002

Maine QIC Membership Roster (For Member Use)
January 2006/REV 1.06/REV 2.06/REV 4.06/REV 5.06

NAME AND CONTACT INFORMATION	POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION (S)	REGULAR CONTACT BY:
DEGON, MARGARET PO Box 2067 Augusta 04338 1-800-870-7746 (W) 623-2144 (W) 622-3130 (H)	Chair	Family Member	2004	All (Ex-officio)	Kennebec	mdegon@mpf.org	*Maine Parent Federation* DIG	Email
HOAD, STEVE 135 Windsor Neck RD Windsor 04363 445-2141 (H)	Vice-Chair Chair, By-laws	Consumer	2004	Adult By-laws Membership	Kennebec	Mainefun40@hotmail.com		Email
POPPELL, CHERYL 56 Birch ST APT 101 Lewiston 04240 753-0873(H) 740-2754(C)	Secretary	Consumer	2005	Adult	Androscoggin	None	PAIMI DRC Board of Directors DIG	Mail Phone
MORRISON, HUGH 692 N Main ST Brewer 04240 989-7786 (H)	Treasurer	Family Member	Charter	Children	Penobscot	imwombat@aol.com		Email
BRAGDON-ROE, KAITLYN 275 Methodist RD Westbrook 04092 409-6765 (H)	Chair, Adult	Consumer	2005	Adult By-laws	Cumberland	KAITBR@Hotmail.com	MAC CAG PAIMI	Email Phone
EVANS, KAREN 145 Spring ST Apt. N Portland 04101 772-7140 (H)		Consumer	1996	Adult	Cumberland	None	Riverview QIC Cemetery Project Cons Adv Board PAIMI DIG	Mail

Maine QIC Membership Roster (For Member Use)
January 2006/REV 1.06/REV 2.06/REV 4.06/REV 5.06

NAME	POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION (S)	REGULAR CONTACT BY:
FAUST, MARYA DHHS 11 SHS Marquadt Building 2nd Floor Augusta 04333-0011 287-4271 (W) 758-8556 (P)		Social Services Medicaid (NV)			Kennebec	Marya.Faust@maine.gov	*DHHS Integrated Services*	Email
HUTCHINS, DAVID DHHS 11 SHS Marquadt Building 2nd Floor Augusta 04333-0011 287-4249(W) 287-7571(FAX)		MH Authority (NV)			Kennebec	David.M.Hutchins@maine.gov	*DHHS* DIG Block Grant Adult MH Planner	Email
KIERSTEAD, JOHN Maine Dept. of Ed. 23 SHS Cross Building Augusta 04333-0023 624-6650 (W)		Department of Education		Children By-laws	Kennebec	John.Kierstead@maine.gov	SPED Federal Grant Data Reporting	Email
LADD, RICHARD SR. 118 Ladd RD Barnard Twp 04414 965-0044 (H)		Family Member	Charter	Children	Piscataquis	rwlsr@hotmail.com		Email
MOORE, ROBERT 27 Lilac LN Augusta 04330 622-7030 (H)		Consumer	2004	Adult	Kennebec	None		Mail

Maine QIC Membership Roster (For Member Use)
January 2006/REV 1.06/REV 2.06/REV 4.06/REV 5.06

NAME	POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION (S)	REGULAR CONTACT BY:
NIELSON, JEAN 377 Western AV Augusta 04330 621-8010 (H) 795-6040 (W)		Family Member	2005	Adult	Kennebec	jnielsen@communities.org OR jenran101102@gwi.net	*Common Ties* Mental Health	Email
STAPLES, KELLY 174 Mere Point RD Brunswick 04011 373-4277 (W) 729-6703 (H)		Family Member	2005	Children	Sagadahoc	Kstaples@Sweetser.org	President, MAPSRC Sweetser	Email
SULLIVAN, MARY BETH 15 Bayview AV S. Portland 04106		Community		Adult	Cumberland	metremblay@gwi.net		
SWASEY-BALLOU, TAMMY 18 Gould ST Camden 04843 236-6110 (H)	Chair, Member-ship	Family Member		Children	Knox	tsballou@verizon.net	Knox/Waldo Cty Jail Board of Visitors and Service Committee Coastal Area NAMI Mid-Coast Health Coalition	Email
TIERNAN, CAROL 15 Rowell ST Madison 04950 1-800-264-9224 (W)	Chair, Children	Family Member	1996	Children	Somerset	tiernan@verizon.net	*GEAR Parent Network* Kennebec Case Review	Email Phone

Maine QIC Membership Roster (For Member Use)
January 2006/REV 1.06/REV 2.06/REV 4.06/REV 5.06

NAME	POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION (S)	REGULAR CONTACT BY:
VITALIS, NED DHHS 11 SHS Marquadt Building 2nd Floor Augusta 04333-0011 287-4255		Children's MH	Non-member	Children	Kennebec	Ned.A.Vitalis@maine.gov	DHHS/CBHS	Email
Vacant		Criminal Justice					Department of Corrections	

PLANNING COUNCIL

ORIENTATION MATERIALS

History and Purpose of Planning Councils

Mental health planning and advisory councils (PACs) exist in every State and U.S. Territory because of the passage of federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992. These federal laws require States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. These laws further require that stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership in the PAC.

States are required to submit yearly applications to receive federal block grant funds. This application is known as the Block Grant Plan. The Mental Health Block Grant program is administered by the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of Public Law 102-321 and block grant planning in general is to support the State creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbances.

The block grant is a formula grant awarded to States based on an allotment calculated for each fiscal year by a legislated formula. Awards are made in response to the States' applications and to the implementation reports submitted by the States for the previous fiscal year.

State applications are developed with input from the State mental health planning and advisory councils and must address the need for services among special populations, such as individuals who are homeless and those living in rural areas. The goal of the Mental Health Block Grant program is to help individuals with serious mental illnesses lead independent and productive lives. The block grant program has served as an impetus in promoting and encouraging States to reduce the number of people receiving care in State psychiatric hospitals, and to develop community-based systems of care.

Federal Legislation

In this section, we summarize the sections of the federal legislation that deal with the duties of the planning council, and later we describe the information that must be included in the State plan.

Membership Composition

Public Law 102-321 is very clear about the composition of mental health planning councils. The federal law (42 USC [United States Code] § 300x-3 [c]) states that planning councils must include the following people:

- Representatives from the following State agencies: Mental Health, Education, Vocational Rehabilitation, Criminal Justice, Housing, Social Services, and the State Medicaid Agency.
- Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.
- Adults with serious mental illness who are receiving (or have received) mental health services
- Families of such adults and families of children with serious emotional disturbances.

Note: The ratio of parents of children with serious emotional disturbances to other members of the council must be sufficient to provide adequate representation of such children.

Most important, the law states that at least 51% of the members should be affiliated with constituency groups other than providers of services or State employees.

Duties of the Membership

The federal law states that the planning council is expected to do the following (see § 300-x [b]):

1. review the Mental Health Block Grant Plan and to make recommendations;
2. serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses;
3. monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Duty 1: Review the Mental Health Block Grant Plan and make recommendations. States are required to submit yearly applications to receive block grant funds. This application is known as the Block Grant Plan. The plans are evaluated according to the criteria established in federal law and explained in the application form. The criteria for the block grant are described on pages 5 and 6 of this toolkit. The Block Grant Plan must be accompanied by a cover letter from the chair of the planning council indicating that members of the planning council have reviewed and commented on the plan. In addition, States are required to submit to CMHS all comments from the planning council regarding the Block Grant Plan.

Ideally, planning is a continuous process and not something that begins upon the release of the application form. Furthermore, we recommend that planning councils be involved in all aspects of the planning process. The planning council and the State should develop a planning timeline that clearly identifies all required tasks and corresponding responsibilities, with planning council roles clearly articulated. This type of timeline should be developed by the State mental health planner and the planning council at the beginning of the year and should include target dates and opportunities for participation.

Current federal law stipulates a yearly planning process with rather strict implementation guidelines. The Center for Mental Health Services allows States to submit two- and three-year plans, but these plans must meet the implementation guidelines established in the federal law. According to this law, States are evaluated on the complete implementation of the Block Grant Plan. If States are found to be noncompliant with this requirement, the federal government has the authority to withhold a portion of the mental health block grant money from the State.

With this said, true system change necessitates a longer planning and implementation time frame. The relationship between planning, budgeting, implementation, and evaluation requires a long-range, strategic form of planning. Many States engage in a strategic planning process in addition to the planning associated with the block grant. You will find a brief overview of strategic planning with suggestions for obtaining additional information later in this toolkit. Copies of State strategic plans can be obtained from the NAMHPAC or NTAC offices.

Duty 2: Serve as an advocate for adults with a serious mental illness, children with serious emotional disturbances, and other individuals with mental illnesses. The membership requirements of PACs are designed to ensure broad stakeholder representation and input into the planning, evaluation, and monitoring of mental health services. Many stakeholders are motivated by their own, or a family member's, involvement with the mental health system. The planning council provides a forum for a variety of advocacy interests to work together to effect change.

Advocacy, which is defined as "to speak on behalf of" or "to argue for" a person, a group, an action, or a cause, includes a wide range of activities. Advocacy is often associated with visible activities on behalf of a cause, such as letter writing, working with the media, educating decision makers, and, in extreme circumstances, public demonstration. Advocacy also embraces the act of learning more about a topic or issue and sharing that information with family, friends, and colleagues, or supporting a cause through community service. The very act of serving on a planning council is a form of advocacy.

There is great variability among planning councils in the way advocacy is accomplished. The federal mandate provides no guidance on this matter, nor does it impose limits on the ways that the planning council can choose to act on its advocacy mandate. In the end, each planning council must decide how it wants to organize itself in order to accomplish this important function. In the examples that follow, we highlight the advocacy activities of a sampling of planning councils.

Example 1: Some planning councils have interpreted the mandate for advocacy to involve legislative monitoring and action. Many planning councils are called upon to testify at legislative hearings, or before other State, regional, and local bodies concerned with mental health service delivery or appropriations. Some planning councils produce white papers on issues of importance within their mental health system, such as the lack of communication between the criminal justice system and mental health system, the needs of children with serious emotional disturbances, or other important issues. This type of advocacy

can also be expressed in position papers, press releases, and other forms of formal communication from the planning council.

Example 2: One mental health planning council has developed a comprehensive legislative monitoring system. Planning council members volunteer to research and track bills related to mental health and to report to the planning council should bills need amendments, or to recommend that the planning council take a position on a particular bill. The council maintains an automated, online bill-tracking service to facilitate this process. This is a highly developed and intense form of legislative advocacy that may be beyond your council's current capacities. However, it serves to show what is possible for PACs in the area of advocacy.

Example 3: Another mental health planning council has engaged in advocacy in several different ways. One of the most successful activities of the council has involved developing a positive relationship with its State Mental Health Administration. The planning council demonstrated the ability to influence the legislative process in a way that was advantageous to the Mental Health Administration. This helped create a foundation of trust and mutual respect. The planning council then convinced the State that all advisory groups concerned with mental health issues should be subsumed under the planning council, thus ensuring that the planning council is the foremost body asked to represent mental health issues within the State. Formerly separate advisory organizations are now accounted for in the committee structure, and the planning council has positioned itself as a leader within the mental health community. The Medicaid Capitation Committee of the planning council wrote a concept paper/proposal for the creation of an independent, mental-health-specific ombudsman program in the State. During the two years that it took for the Office of the Ombudsman to be established, the planning council kept the pressure on and ultimately met with success.

Planning councils may also wish to consider working in coalition with other advocacy organizations and reform movements within their State. Ideally, the planning council meeting should be the forum where a diversity of reform activities in the State are discussed. Some planning councils have found it helpful to establish a standing advocacy committee that discusses public policy issues and current events. This committee also develops action items related to these issues and presents recommendations to the entire council.

Duty 3: Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State. This is arguably the most difficult task facing planning councils because of the broadness of the mandate and the resources, time, and energy that it requires. We do not know of any State that has been found noncompliant for not fulfilling this part of the PAC mandate. However, many PACs are not even aware that evaluation and monitoring are part of its responsibility.

Based on this, there are several efforts underway in this area and new models and information are becoming available everyday. There are a variety of ways that planning councils can approach this task, ranging from designing new initiatives to taking advantage of existing programs.

There are a few planning councils that have approached this task in creative ways.

Example 1: In one southern State the mental health planning council participated in the Peer Review Team visitation of their State's 15 community mental health centers and two state hospitals. The Adult Community Services Peer Review team has established a process for assessing the strengths and weaknesses of community programs from the perspectives of primary consumers, family members, and community mental health service providers, thus establishing a monitoring process that also provides technical assistance at the community level.

Example 2: Another mental health planning council has partnered with the Office of Behavioral Health Services in creating a process and instruments for the evaluation and allocation of federal block grant monies. This process includes the review of program requests for funding and recommendations for fund allocation from the planning council. Once funding decisions are made, the planning council also partners with the State to conduct on-site utilization reviews of public mental health service providers.

Although there are some examples of planning councils that have created new initiatives, evaluation is not a process that the planning council must approach on its own. There are several national initiatives funded by the Center for Mental Health Services that can be of use to planning councils for their evaluation activities. These initiatives include the following:

- **The Mental Health Statistics Improvement Program (MHSIP)**
  This program seeks to build the capacity for uniform, comparable statistical information about mental health services to enable broad-based research on systems of care and models for service delivery.

Most notable in this project was the development and implementation of a consumer-focused mental health report card for managed care that is in use in many States. You may want to find out if your State is using the MHSIP report card and how the data is being utilized to monitor and evaluate services.

- **The 16- State Pilot Indicator Project**
  This is a grant program from the Center for Mental Health Services operating in 16 States. The purpose of these grants is to pilot 32 selected performance indicators in participating States. This grant effort stems from the growing need to have information on the performance of existing mental health systems and services for improved planning. Part of this program focuses on the development of common performance indicators across participating States that will allow for the comparison of similar data. This program requires stakeholder input, and the planning council should be aware of developments in the project. The States participating in this project include: Arizona, Colorado, Connecticut, Illinois, Indiana, Missouri, New York, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, and Washington D.C.

NAMHPAC hopes to survey planning councils regarding the level of activity in the evaluation and monitoring of mental health services. Once complete, this survey will enable the identification of promising practices in evaluation that will be replicable by other planning councils.

Criteria for Mental Health Block Grant Plan

States are required to submit yearly applications to receive block grant funds. This application is known as the Block Grant Plan. The Block Grant Plan is evaluated according to the five criteria established in Federal Law 102-321, section 1912(b).

Five Consolidated Criteria

Criterion 1: Establish a comprehensive community-based mental health service system

- Establishment and implementation of comprehensive community-based mental health service system
- Reduction of hospitalization
- Description of available services and resources in a comprehensive system of care, including case management

Criterion 2: Estimate the prevalence and treated prevalence of mental illness

- Establish quantitative targets for services
- Estimate prevalence rates of serious mental illness (SMI) and serious emotional disturbance (SED)

Criterion 3: Establish management information systems

- Identify financial resources, staffing, and training
- Estimate the manner in which the State intends to expend the Block Grant funds

Criterion 4: Identify targeted service to homeless and rural populations

- Describe outreach efforts and services to the homeless
- Describe service provision to rural areas

Criterion 5: Specify provisions of children's service

- Describe comprehensive community-based service for children with SED

How to Be an Effective PAC Member

This toolkit focuses on the duties, responsibilities and possibilities of planning and advisory councils in improving the planning, evaluation and delivery of mental health services. The potential of planning councils is only realized through the active involvement of individual members. For those new to planning

councils, we highlight some strategies for making sure your voice is heard and for advancing the effectiveness of your planning council.

Even though mental health systems are recognizing more and more the importance of stakeholder oversight, many barriers prevent mental health consumers, family members and parents from participating in policy and decision making. There are now resources designed for and by these groups to help insure an active voice for stakeholders.

The National Mental Health Consumers' Self-Help Clearinghouse has prepared the *Self-Advocacy Technical Assistance Guide*, which helps mental health consumers identify and develop strategies for overcoming obstacles they face. Many of the principles discussed in this curriculum are relevant to mental health planning councils in their work. Information on contacting the Clearinghouse is located in the resources section of this toolkit. Below we highlight some self-advocacy strategies.

The most important principle in self-advocacy is the belief that you are someone worth advocating for. Once you believe in yourself, it is often possible to be more assertive. Sometimes our moods may prevent us from being as assertive as we need to be, or sometimes there is a fear of reprisal or punitive measures.

A very simple first step to becoming assertive is to ask the question, "why?" when confronted with conditions or situations that do not seem to make sense. This lesson is as important in mental health planning as it is in service delivery.

Very often our reasons for becoming involved in mental health advocacy stem from our own or a family member's involvement with the mental health system. At its worst, the mental health system can be fragmented and unresponsive to the needs of vulnerable persons. Sometimes these kinds of experiences lead to anger, which if not directed appropriately, may actually make self-advocacy and appropriate assertiveness difficult. Use your anger appropriately to motivate actions, but control it so that it does not become a liability to your efforts.

The National Consumer–Supporter Technical Assistance Center located at the National Mental Health Association has published a booklet titled *How to Develop and Maintain a Consumer Advisory Board* that offers these tips:

General Expectations

- **Know your PAC's mission, purposes, goals, policies, strengths and needs.** Review the material in the orientation manual, and ask questions about things that do not make sense to you. Find another member of the council of whom you feel comfortable asking questions and find out about the work and functioning of the planning council.
- **Bring goodwill and a sense of humor to the PAC's deliberations**. Things will not always go as hoped. It is important to be persistent and to demand what is right, but don't let little things keep you from addressing the important issues.

Meetings

- **Prepare for and participate in all PAC and committee meetings.** Read materials that are sent out ahead of time. Ask questions of the chair or other committee members if things do not make sense to you. Learn where you can get answers to your questions. Take advantage of the resources listed in this toolkit.
- **Complete assignments on time and present results as requested.** You want people to take you seriously and to know that you are a valuable member of the planning council; this is better accomplished through action and example.
- **Feel comfortable asking questions; other people are probably wondering the same thing.** By asking questions, you are indicating your interest in the work of the planning council and that you do not just blindly accept what people tell you.
- **Make an effort to know the larger mental health community.** Attend community meetings and events as time allows. The planning council is but one avenue for change in the mental health system, and it needs the information from the larger mental health community to make the best decisions possible.
- **Know your organization or constituency.** Make a point to share information with the PAC about your constituents' work, and vice versa. If you represent a particular interest group, make that perspective known, but try not to become myopic. The goal of planning councils is to make

recommendations that are good for all the persons and populations served by the mental health system.

- **If you have a topic that you wish to add to the agenda,** follow through to make sure that it is addressed. Talk with other PAC members and the chair to have it placed on the agenda.

Having expectations for your own involvement on the planning councils does not absolve others of theirs. In general, the planning council and the state mental health administration must make a commitment to making the planning council effective. There are some generally agreed upon components that make stakeholder participation meaningful; they include:

- cultural competency;
- ongoing training;
- ongoing logistical support and child-care support;
- adequate and timely information and staff support to allow for in-depth consideration of complex issues;
- open meetings on a regular schedule and in a location and setting convenient and welcoming to PAC members;
- open meetings fostering meaningful and respectful dialogue among PAC members and decision makers;
- broad dissemination of minutes and reports to PAC members;
- staff follow-up to assure that PAC members are informed of the results of meetings and that the results are effectively disseminated for maximum impact.
- As more outcome data and consumer report card results becomes available, this information must be disseminated in a timely manner to PAC members, and used as a tool in the planning, evaluation and monitoring processes.
- Organizational development activities should be given a priority to increase board effectiveness.

Strategic Planning: An Overview

The information on strategic planning is taken in large part from the FAQs (Frequently Asked Questions) section of the Alliance for Nonprofit Management's Web page. For more detail on strategic planning, or other nonprofit development issues, please visit their site at http://www.allianceonline.org. You can reach the Alliance by dialing (202)955-8406.

The FAQs were inherited from Support Centers of America (SCA) following a merger between SCA and Nonprofit Management Association (NMA), and are now a product of the Alliance for Nonprofit Management.

What is strategic planning?

Strategic planning is a management tool, period. As with any management tool, it is used for one purpose only: To help an organization do a better job – to focus its energy, to ensure that members of the organization are working toward the same goals, to assess and adjust the organization's direction in response to a changing environment. In short, strategic planning is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it, with a focus on the future. (Adapted from Bryson's *Strategic Planning in Public and Nonprofit Organizations.*)

Planning Councils 101: Improving the Effectiveness of Your Planning Council

History and Purpose of Planning Councils

- As a result of federal law **99-660** in 1986, continuing through Public Law **101-639** and Public Law **102-321** in 1992, and continued in the current **106-310**, mental health planning and advisory councils (PACs) exist in every State and U.S. Territory.
- These laws require States to perform mental health planning in order to receive federal Mental Health Block Grant funds

History and Purpose continued...

- So what are block grants?
  - The block grant is a formula grant awarded to States based upon an allotment c alculated for each fiscal year by a legislated formula.
  - Awards are made in response to the States' applications and to the implementation reports submitted by the States for the previous fiscal year

Block Grant Formula?!?!?!

State Allotment = A (x/u)

$Xi = Pi \cdot C\,Si) \cdot [g$ reater of 0.4 or $\{1 - .35\ Ri\ \%/Pi\ \%)\}]$

$U = \sum_{i=1}^{51} Xi$

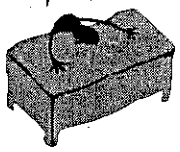
$Pi = 0.107\ (\#\ 18 - 24) + 0.166\ (\#\ 25 - 44) + 0.99\ (\#\ 45 - 64) + 0.082\ (\#\ 65 + i)$

$CSi = 0.75\ Wi + 0.15\ Re + 0.10\ Sui^{2}$

$Pi\ \% = Pi \div \sum_{i=1}^{51} PIX100$

$Ri\ \% = Avg.\ TTRi\ (last\ 3\ yrs.) \div Csi$

$\sum_{i=1}^{51} Pi \quad Avg.\ TTRi \div Csi$



Historical Purpose of Block Grant

- Deinstitutionalization
- Case Management
- Outreach

= A method to drive system change for comprehensive community-based care

Provisions of the Block Grant

- In the year 2000, block grant evolved into the five criteria we see today.
- Adult/Child Plans
- Criterion:
  - Criterion 1: Comprehensive Community Based System of Care
  - Criterion 2: Mental Health System Data Epidemiology
  - Criterion 3: Children Services
  - Criterion 4: Targeted Services to Rural and Homeless Populations
  - Criterion 5: Management Sys tems

Criterion One: Comprehensive Community Based System of Care

- Comprehensive array of services (e.g. case management, medical, dental, education)
- Co-Occurring/Substance Abuse Disorders
- Analysis of strengths, weaknesses, and priorities
- National Outcomes Measures
  - e.g. reduced utilization of psychiatric inpatient beds within 30 days of discharge
- Evidence-Based Practices
  - Type, number of programs, and numbers served

A Quick Glance at NOMS:

- Why use NOMS?
  - Measure of system performance
  - Statistics/quantifiable data are tools in influencing public policy
  - Uniform way of measuring state progress
- State Specific Performance Indicators
  - Reflect priorities of state
- Be sure plan has:
  - Description of data (numerators/denominators)
  - Multi-year targets

Sample State Specific Indicator:

Amount Spent on Peer Run Support Services
Population: Adults Diagnosed with a Serious Mental Illness
Criterion 5: Management Sys tems

	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	$120,0000	$120,000	$145,000	$160,000	$160,000
Numerator	n/a	n/a	n/a	n/a	n/a
Denominator	n/a	n/a	n/a	n/a	n/a

Description: The Performance indicator represents the state's Community Mental Health Block Grant funds commitment to enhancing peer-run support services throughout the state. Currently, 4 projects have been funded and two more are under review, based on responses from a Request for Proposals. Peer to Peer initiatives promote recovery and well being, and have been identified as one of five top public policy priorities in the Planning Council's strategic plan.

Criterion Two: Mental Health System Data Epidemiology

- Prevalence – total number of cases of a given mental illness within a specific population
- Incidence – total number of new cases in a specific population in a given time span
- National Outcomes Measures
  - Increased Access to Services

Criterion Three: Children Services

- Integrated Service System
  - Social Services
  - Educational Services
  - Juvenile Services
  - Substance Abuse Services
  - IDEA

Criterion Four: Targeted Services to Rural and Homeless Populations

- Outreach Service for homeless
- How community-based services will be provided to individuals residing in rural areas

Criterion Five:
Management Systems

- Allocation of resources
- Staffing
- Training of mental health providers
- Training of emergency health service providers

Additional Provisions

- Planning Council
  - Composition/Membership
  - Duties
- Maintenance of Effort
  - States will maintain expenditures for community mental health services at equal or more than the average level of the previous 2-year period preceding the fiscal year for which the state is applying for the grant

What the Block Grant CAN NOT be used for...

- Inpatient services
- Cash payments to intended recipients of health services
- Purchase of land/major remodeling of facilities
- Providing financial assistance to any entity other than public/non-profit private entity

Reviewing the Block Grant

- Don't wait! Use previous years plan to submit recommendations.
- Ensure plan is reflective of the systems strengths, weaknesses and priorities – as *you* see them
- Tools for Reviewing:
  - Reviewers Checklist ☑

Using the Public Comment Period Effectively

- Organize/Mobilize constituents to respond to request for comments/public forums
- One Consumer/Family Voice – Speak the same message
- Clearly articulate goals and vision of the system
- Provide specific, realistic suggestions/recommendations – don't just critique!

Membership Composition

Planning Councils must contain the following people:

- Representatives from the following State agencies:

  Mental Health, Education, Vocational Rehabilitation, Criminal Justice, Housing, Social Services, and the State Medicaid Agency

- Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services

Membership Composition Continued....

- Adults with serious mental illness who are receiving (or have received) mental health services.
- Families of such adults and families of children with serious emotional disturbance.

Membership Composition Con...

- The ratio of parents of children with serious emotional disturbance to other members of the council must be sufficient to provide adequate representation of such children.
- Most importantly, the law states that not less than 50% of the members of the councils are individuals who are NOT State employees or providers of mental health services.

Additional Members to Think About:

- Youth representation
- Older Adult representation
- Aging Agency representation
- Dedicated seats to advocacy organizations
  - Pros/Cons of having dedicated seats

Ensure FAMILY/ CONSUMER Involvement

- A consumer-run system...
  - CA PAC: monitors frequency of consumer/family participation and actively solicits input if not getting enough
  - CA PAC: *Leadership Committee* of Chair, Vice Chair, Committee Chairs – debrief after each meeting to discuss how things could have been run better/how to deal with internal issues
  - PA PAC: Co-chairs, one MUST be a consumer or family member

Committee Structure Options

- Variety of ways to structure committees – no ONE right way, do what's right for your council:
  - Membership, Block Grant, Legislative, Media Relations, Executive
  - Adult, Child, Older Adult
  - Ad-hoc/issue based committees
  - Strongly recommend having Membership and Executive Committee

Duties of the Membership

1. To review the Mental Health Block Grant Plan and to make recommendations.
2. To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Duty 1: Review

- States are required to submit the Planning Council's letter with the block grant application
- Planning councils should be involved in all aspects of planning, not just serve as review

Duty 1: Review

- Planning should be a year-long process
- Develop a planning timeline with the State
- Strategic planning – budgeting, evaluation, data
- Consider Block Grant Subcommittee

Duty 1: Review

- What the authority can do to help:
  - Put it in Plain English
  - Give people enough time to look at the plan and give feedback
  - Provide the council with a final version
  - Make the data easy to understand

Duty 2: Advocate

- Can take many forms – letter writing, working with media, educating decision makers
- Educate yourself about the issues – share with family, friends, colleagues
- Legislative advocacy – informing and educating

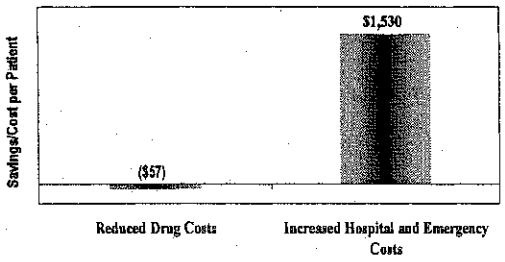
Task: Serve as an Advocate

- Planning Councils (and other advocacy groups) can be powerful and strategic allies in bringing about change in mental health systems
- Advocates can speak where often state (regional, local) employees cannot
- Forge alliances and RELATIONSHIPS so that the interests of both the advocates and the MH authority can be advanced

Serving as Advocates

- To be effective advocates, people must be educated about the issues
- Advocates must have DATA available about the issues they are addressing
- Present the information in a powerful way
- Must speak with ONE VOICE

Impact of Medicaid Drug Reimbursement Limits



Soumerai SB, et al. *N Engl J Med.* 1994;331(10):650-655.

Sample Advocacy Efforts:

- AL PAC: Anti-stigma campaign – PAC collaborated with advocacy groups, local news stations and other healthcare groups to create commercials and billboards
- CO PAC: Legislative Day, testifying at hearings, closely track legislation
- ND PAC: Legislative Breakfast – gives award to state legislator who has been the mental health champion
- FL PAC: Quarterly newsletter disseminated statewide

Duty 3: Evaluate

- Broad mandate with little specificity
- Some councils conduct peer-reviews of CMHCs and hospitals
- Some councils review the services provided by block-grant funded providers
- Data improvement efforts – MHSIP
  - WWW.MHSIP.ORG
- NOM basic and developmental indicators

Sample Monitoring and Evaluation Activities:

- AL PAC: ACT Fidelity Assessment Teams
- TN PAC: Longitudinal survey of 95 county jails, led to initiatives for cross-training, jail diversion, education
- NV PAC: Collaborated with Mental Health Department to do Consumer Survey on perceived quality of outpatient services in NV
- RI PAC: Created subcommittee to investigate 100% increase in state funded acute psychiatric hospitalization from 1996 to 2001 – published results in report with recommendations which were responded to by mental health division to remedy problem

Increasing Planning Council Effectiveness

Challenges Facing Planning Councils

1. Holding regular PAC meetings and promoting consistent attendance
2. Assisting Parents of Minor Children in attending PAC meetings
3. Developing education and training opportunities for PAC members including consumers and family members
4. Recruiting a diverse and culturally competent membership
5. Recruiting key players

Challenges Continued...

6. Exerting greater influence over the state mental health administration
6. Dealing with political and administrative changes
7. Affecting State legislative agendas
8. Effectively monitoring state plans and mental health systems (beyond the community mental health block grant)

COUNCIL BEST PRACTICES

Have a focus/purpose

- People need to feel that their participation is making a meaningful difference
- Develop a mission/vision for the council
- Identify two or three key goals for the council – Avoid the Shotgun Approach

Education is Key

- Members need to understand why they are there
- Orientation process for new members
- Mentors for new members
- Ongoing education
- Use council members to educate other members (e.g., use reps from other agencies to educate on issues)

Meetings

- Length of meeting should match the effort and cost expended to get there
- Stick to the agenda
- Honor people's time-start and end on time
- Number of times council meets varies on state – not always quantity but quality
  - Monthly
  - 6 times a year
  - Quarterly with longer, multi-day meetings
  - Committee work in between meetings!

Have an agenda

- Each meeting needs to have an agenda
- All constituencies should have input
- Who develops/manages the agenda....an important issue

Bylaws: Key Issues to Consider

- Term limits
  - Pros/Cons
- How to deal with disruptive council member
- Leadership Development as integral part of council:
  - Past Chair, Current Chair, Vice Chair model

Components that make stakeholder participation meaningful

- Cultural competency
- On-going training
- On-going logistical support and child-care support
- Adequate and timely information and staff support

Components that make stakeholder participation meaningful con...

- Open meetings, on a regular schedule, and in a location and setting convenient and welcoming to PAC members
- Open meetings fostering meaningful and respectful dialogue among PAC members and decision makers
- Broad dissemination of minutes and reports to PAC members

Components that make stakeholder participation meaningful con...

- Staff follow-up to assure that PAC members are informed of the results of meetings and that the results are effectively disseminated for maximum impact
- As more outcome data and consumer report card results becomes available, this info needs to be disseminated in a timely manner to PAC members, and used as a tool in the planning, evaluation and monitoring process

STRATEGIES TO MAKE A DIFFERENCE: AN OVERVIEW

- Work through a coalition
- Research all of the angles
- Work with the media to get your message out

WORK THROUGH A COALITION

- Seek participation from a wide variety of professional and advocacy groups.
- Be respectful of differing opinions, but focus on areas of consensus and make compromises that are acceptable to the whole group.
- implement a system for regular meetings and other types of communication.
- Develop a concrete list of responsibilities (specific steps) with timelines so that each member is involved, but not overwhelmed.
- A coalition's voice will be more powerful than the voice of a single individual or group.

RESEARCH ALL OF THE ANGLES

- Identify barriers to achieving your goals.
- Obtain studies, data, and other resources that will help you to effectively make an argument.
- Network with experts from across the country.
- Know what your opponents are saying and be prepared to respond to their concerns.
- Have a firm understanding of the political climate and who the key decision makers are for your issues.

WORK WITH THE MEDIA

- Identify and build relationships with key media contacts.
- Develop sample press releases, letters to the editor, and other media materials.
- Plan events to raise awareness as the legislative session begins (town hall meetings)

PROMISING PRACTICES HANDBOOK: Strategies to Improve the Effectiveness of Your Planning Council

DEVELOPED BY:
The National Association of Mental Health
Planning and Advisory Councils

FUNDED BY:
The Center for Mental Health Services,
Substance Abuse and Mental Health Service Administration

The National Association of Mental Health Planning and Advisory Councils (NAMHPAC) is the national organization for State and regional planning organizations throughout the United States and its Pacific Territories and is dedicated to providing technical support, opportunities for state-to-state networking, and a national voice on mental health planning issues. NAMHPAC is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Table of Contents

Introduction

Experience tells us that the success or failure of a program of mental health services depends in large part on the effectiveness of two-way communication between the providers of services and the people they serve. This truth from clinical practice also applies to the planning, implementation and oversight of mental health systems on the state and community level..

Federal and state leaders have recognized the wisdom of citizen oversight, resulting in the formation of federally mandated mental health planning councils. Planning councils are expected to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems. Although these activities are mandated, many states do not provide funding to support them. In many cases, lack of funding and member turnover prevents these organizations from having their full impact on service delivery and consumer empowerment.

In response to these challenges the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) is pleased to present this resource to planning and advisory councils. It is our hope that this handbook will aid your council in crafting innovative solutions to some of the challenges it faces. We thank the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration for funding for this project. Please note that all the materials in this handbook, except where noted, are in the public domain and may be reproduced and distributed by your PAC.

Although this handbook does not provide a comprehensive analysis of each challenge, it does represent the ideas and real-life practices of PACs throughout the country. More thorough analysis would require knowledge of the specific challenges facing each state. Such an analysis can best be accomplished through peer-to-peer technical assistance with other council members, such as the NAMHPAC board of directors and technical assistance team. (Please see the Resources section of this handbook for more information). For more information on technical assistance through NAMHPAC, call (703) 797-2595.

History and Purpose of Planning Councils

Mental Health Planning and Advisory Councils (PACs) exist in each state because of the passage of P.L. 99-660 in 1986 and continuing through P.L. 101-639 and P.L. 102-321 in 1992. These federal laws require states to perform mental health planning in order to receive federal mental health grant funds. These laws further state that stakeholder groups, including mental health consumers, their family members and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the PAC.

States are required to submit yearly applications to receive block grant funds. This application is known as the Block Grant Plan. The Mental Health Block Grant Program is administered by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of P.L. 102-321 and block grant planning in general is to support the state creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance.

The Block Grant is a formula grant awarded to states based on an allotment calculated for each fiscal year by a legislated formula. Awards are made in response to the states' applications and to the implementation reports submitted by the states for the previous fiscal year.

State applications are developed with input from the state Mental Health Planning and Advisory Councils and must address the need for services among special populations, such as individuals who are homeless and those living in rural areas. The goal of the Mental Health Block Grant Program is to help individuals with serious mental illnesses lead independent and productive lives. It has served as an impetus in promoting and encouraging states to reduce the number of people receiving care in state psychiatric hospitals and to develop community-based systems of care.

Membership Composition

- State agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, social services and the state Medicaid agency.

- Public and private entities concerned with the need, planning, operation, funding and use of mental health services and related support services.
- Adults with serious mental illness who are receiving (or have received) mental health services.
- Families of mentally ill adults and families of children with serious emotional disturbance
  - The ratio of parents of children with serious emotional disturbance to other members Of the council must be sufficient to provide adequate representation of such children.

At least 51% of the members should be affiliated with constituency groups other than providers of services or state employees.

Duties of the Membership

1. Review the Mental Health Block Grant plan and to make recommendations.
2. Serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance and other individuals with mental illnesses.
3. Monitor, review and evaluate—not less than once each year—the allocation and adequacy of mental health services within the state.

Block Grant Criteria/Elements

States are eligible to receive Block Grant funds only if its plan meets the five criteria established in P.L. 102-321 for the adult and child plans. The list below outlines the five criteria for planning purposes.

Criterion 1: Establish a comprehensive community-based mental health service system

- Establishment and implementation of comprehensive community-based mental health service system
- Reduction of hospitalization
- Description of available services and resources in a comprehensive system of care, including case management

Criterion 2: Estimate the prevalence and treated prevalence of mental illness

- Establish quantitative targets for services
- Estimate prevalence rates of serious mental illness (SMI) and serious emotional disturbance (SED)

Criterion 3: Establish management information systems

- Identify financial resources, staffing and training
- Estimate the manner in which the state intends to expend the Block Grant funds

Criterion 4: Identify targeted service to homeless and rural populations

- Describe outreach efforts and services to homeless
- Describe service provision to rural areas

Criterion 5: Specify provisions of children's service

Describe comprehensive community-based service for children with SED

Common Challenges Facing Planning Councils

In considering the many challenges facing PACs in addressing the federal mandate, it is difficult to craft a one-size-fits-all solution. Every PAC faces particular challenges that are shaped by the needs and structure of their particular mental health system.

NAMHPAC developed this initial list of challenges from its technical assistance work with a variety of PACs around the country. NAMHPAC board members and technical assistance trainers crafted possible solutions based on their experience and on what they have seen done in other states. These responses were then field tested with a diverse group of planning council chairs and members.

Challenge # 1 - Holding regular PAC meetings and promoting consistent attendance
One of the basic challenges facing many PACs is infrequent meetings and poor attendance. Without regularly scheduled and meaningful PAC meetings that draw a group of core members, it is difficult for a PAC to carry out its federally mandated agenda.

Strategies
There is no set rule for the number of times that a PAC should meet during the year. Whereas some states meet monthly, it is more common for a PAC to meet less frequently, such as four times a year, with planning council staff and committees conducting business between meetings. However, it is essential that each meeting have a concrete and meaningful agenda and that the actions taken at the meeting are followed up on by state planning staff and responsible council members so that participants can see that their work has had a meaningful impact.

In designing PAC meetings, the following factors should be considered:

- **Meeting content.** Without a meaningful agenda, participants will see little point in attending meetings. PAC meetings must be more than opportunities to share thoughts on various mental health issues. There must be a formal agenda-setting process that keeps the meeting focused on substantive issues.
- **State agency support.** State agencies must continually offer support to PAC meetings. In addition to attending the meetings and staffing the council, the agency should provide financial support to PAC members who would not otherwise be able to attend, especially those whose jobs do not reimburse them for their time and expenses. Child care for parents with minor children should be addressed in the budget for the PAC. Agency staff also should work to schedule meetings so that they do not conflict with other meetings (or perhaps so that they coincide or "piggyback" with other state meetings). Of course, meetings should be scheduled well in advance and notices should be sent out with logistical support. In partnership with relevant committees, state agencies also should implement the recommendations and action steps identified by the councils.
- **Use of technology.** Although there can be no substitute for in-person meetings, improvements in technology can support PAC communications. Additional meetings could be held by means of conference calls and, in states where geography is a particular problem, PACs and state agencies could invest in video conferencing equipment with potential cost savings. Individual members and committees can utilize e-mail as a method of communication, and some Internet providers, such as America Online, provide electronic meeting rooms for members.
- **Accessibility.** PAC meetings should be held in accessible locations and in accessible facilities. In some states, the capital city may be strategically located so that it is an equal distance to the rest of the state. In other states, it may be a good idea to establish a rotation schedule and periodically hold meetings in other parts of the state. It is also important that the buildings used are easily accessible to those with disabilities or other special needs.
- **Initial orientation.** As with any board or council, new members may find themselves confused or overwhelmed by PAC activities. PACs should develop orientation materials for new members as well as set aside time for training for new members to make them aware of the history of the council, its responsibilities and its current activities. Another idea would be to create a mentoring system that pairs new and veteran council members and sets up formal and informal time for them to work together.
- **Member participation.** If recruited correctly, the planning council will mirror a "who's who" of the mental health stakeholder community, including mental health consumers, family members,

community-based providers and state agency representatives. These members should share their expertise in presentations before the PAC. For example, when discussing housing, a PAC could bring together a panel including a housing provider, a family member whose relative lives in community housing and a consumer who is a resident—all of whom are council members. This active presentation will contribute to greater interest in attending meetings.

Challenge # 2 - Assisting parents of minor children in attending PAC meetings
Parents of minor children are one of the key groups of stakeholders who should be included in the PAC. This has been challenging in many states because many parents of young children must work during the day at jobs that may not be connected to mental health issues and are unlikely to reimburse them for their expenses.

Strategies
There are several actions that PACs could take to support parents of children. Whereas the following suggestions are appropriate for involving parents of children, they also will result in increased attendance among other groups of stakeholders.

- **Compensation.** In addition to reimbursement for expenses, PACs should consider stipends for parents of children (and others) to help them afford time off of work.
- **Day Care.** PACs could provide child care opportunities for parents while they attend the meetings.
- **Scheduling.** When PAC meetings are not held for multiple days, they could be scheduled in the evenings so that work is not missed. When multiple-day meetings are required, they could be held over weekends.
- **Outreach.** PACs should work closely with the statewide associations and advocates of the groups that they are trying to recruit. For example, when trying to recruit parents of minor children with serious emotional needs, it would make sense to work with the state and local chapters of the Federation of Families for Children's Mental Health or other local advocacy organizations interested in this group of consumers.

Challenge #3 - Developing education and training opportunities for PAC members, including consumers and family members
Many PACs recruit members from a broad range of stakeholders. Unless new members are provided orientation and training pertaining to the responsibilities of the PAC, they may be confused about their roles and be unable to make a meaningful contribution. In addition, the tasks facing PACs range from new innovations in community-based services to complex analysis of managed-care contracts. PAC members require consistent training and support as they monitor these changes.

Strategies
Planning and Advisory Council membership should begin with a solid orientation program, possibly including mentorship with veteran council members. From that point on, PAC meetings should be structured to provide continuous opportunities for training and education. One of the easiest ways to do this is to structure formal training time into each PAC meeting. PAC members with particular expertise in a given area should be asked to make presentations to the rest of the PAC and serve as peer-to-peer consultants in the areas of their expertise. Because a well working PAC's membership will mirror the state's mental health stakeholders (consumers, family members, advocates and so on) it should be easy to assign various PAC members to make presentations and to serve as on-call experts to both planning staff and PAC membership.

Many PACs also provide training outside of PAC meetings through technical assistance meetings and retreats. NAMHPAC has delivered technical assistance to representatives of PAC councils in various states through short meetings and multiple-day trainings. Trainings are tailored to match the particular needs of each council by providing them with the knowledge of a network of peer-to-peer trainers. Trainings have been supported in various ways, both through limited federal funds and state financing.

Challenge #4 - Recruiting a diverse and culturally competent membership
Planning and Advisory Councils are the places where a statewide community comes together to evaluate community mental health services. To be fair and effective, such analysis must include the perspectives of mental health stakeholders throughout the state, with careful thought given to the impact of recommendations and services on people of different races, cultures, gender, sexual orientation and geographical location.

Strategies
Many PACs currently are in the process of addressing these challenges. Whereas many PACs carefully recruit members to create a good mix of stakeholders (urban, rural, African American, Latino, Asian/Pacific American, male, female and so on), many councils are working to go beyond representative diversity and achieve true cultural competency. Membership committees must make an effort to continually evaluate the composition of the planning council and plan strategically when vacancies occur.

Groups representing diverse constituencies can be invited to the council and be asked to make presentations regarding the specific needs of their constituencies or discuss the way that traditional services may not adequately serve them. Cultural competency committees can be established to make recommendations that specifically address the needs of diverse communities and to provide a second level of monitoring and evaluation to make certain that the PAC does not reflect a single viewpoint.

Challenge #5 - Recruiting key players to the PAC table
As has been stated throughout this handbook, a PAC is only as good as the members who comprise it. Unfortunately, in some states key mental health stakeholders do not serve on the PAC. Potential leaders may be ignored by administrative officials who want to keep close control of PAC activities, or they may not perceive the PAC as a meaningful place body in which to invest their time.

Strategies
Once again, unless PAC recommendations have a meaningful impact on the planning and delivery of services, potential PAC members will rightly perceive membership as an ineffective use of their time. Unfortunately, this is a bit of a "chicken-and-egg" dilemma. Unless key players are involved in the PAC, it will be unable to truly have an impact on administrative and legislative decisions. But without this impact, key players will be unlikely to participate in the first place.

The solution to this challenge begins with the relationship to the state agency that manages PAC activities. From the state's mental health commissioner down, the PAC must be viewed as the place with which to nurture collaboration and broad, participatory feedback. To recruit key stakeholders, the administration may be a good place to begin. In addition to offering their own time, they could make requests to mental health advocates who will be inclined to accept the appointments. In turn, these key players can construct a recruitment committee that can work to make sure that expertise and new perspectives are consistently sought out and brought into PAC activities.

As key players are recruited, the PAC should simultaneously focus on making the time they spend with the PAC meaningful. The agenda-setting process should be carefully monitored to make sure that key issues are addressed and substantive meetings are maintained. Year-long action plans with concrete outcomes also should be developed that focus on specific action items, such as managed care, cultural competence, contracting, training and so on. Progress by the PAC in selected areas should be evaluated to determine how the PAC could function better or to demonstrate the quality work of the PAC in order to recognize valuable members and recruit new ones.

Challenge #6 - Addressing new issues, such as managed care and juvenile justice
Although the primary role of the PAC is to evaluate and monitor use of the Community Mental Health Block Grant, PACs are also mandated to evaluate all community mental health services within their state. This necessitates knowledge of trends that are impacting services such as managed care contracts (which may or may not involve block grant funds), incidences of people with mental health disorders in the adult or juvenile justice system and other issues impacting people with mental health disorders.

Strategies
Policy and Advisory Councils should routinely provide education programs delivered by people who understand both the issues involved and the role of the council. PACs can best address these issues by tying into public and private organizations and individuals who are connected to broader issues. For example, representatives of various stakeholder groups (consumer or parent groups, mental health associations, local or state affiliates of the National Alliances for the Mentally Ill, protection and advocacy organizations, etc.) could be invited before the council to present on a particular issue and make proposals for further action. Ideally, these organizations will already be represented on the council.

In some states, "town hall" meetings are held during council meetings that include the mental health commissioner, the entire council, and stakeholders from around the state. Experts could be brought in to speak on model programs, followed by an open PAC dialogue. Action steps could be developed for follow-up by relevant committees, planning staff and additional input from the stakeholder groups working on the council. These efforts can go beyond fact-finding efforts and broad discussions, and be

incorporated into the regular activities of the PAC. For example, the state could provide regular updates on managed care contracts for analysis by and recommendations from the council.

It is important to bring other state agencies into a formal relationship with the council. This can include seats on the council itself for representatives of organizations such as the Division of Family Services, juvenile justice administrations, office of managed care and so on. The PAC could play an excellent role as a coordinator of action between these various bodies, making recommendations for integrated responses to the issues before them.

Challenge #7 - Exerting greater influence over the state mental health administration
Many PACs are seen exclusively as monitors of the community mental health block grants and as advisors to mental health agencies in this limited domain. A major challenge facing PACs in many states is to improve their relationships with the state mental health administrations so that they are made an integral part of community mental health services decisions. Although their role will always be advisory, PAC recommendations should carry the weight of statewide consensus among a diverse group of stakeholders. It is important that such influence extend beyond the community mental health block grant to services across the state.

Strategies
Positive relationships will have an impact on influence of the planning council. The extent of council influence is also determined by structure. Several questions will help determine the strength of the council in affecting state decisions:

1. **Who staffs the PAC?** In some cases, PACs are staffed by administrative officials who are too far down in the state's hierarchy to implement council recommendations. In these cases, the council may make recommendations with the solid support of those who provide staff support only to have their recommendations ignored by staff who have decision making authority. Staff specifically assigned to support the PAC should have support and decision-making authority within the agencies for which they work.
2. **Which state agencies are represented on the PAC?** Planning and Advisory Councils should have representation by high-level state staff who can take recommendations back to their respective agencies and use meetings as an opportunity for collaborative planning. Unfortunately, it is often difficult to bring in meaningful involvement by agencies that are not directly related to the PAC. Many PAC experts consulted for this handbook cited problems in ensuring attendance from outside state agencies.
3. **What groups are represented on the PAC?** If the PAC membership represents the independent advocacy voices of the state, these advocates may be able to take recommendations even further. State administrative officials may be able to ignore the concerns of a council that serves under their authority; but when consumer, parent and other advocacy organizations in the state are prepared to launch advocacy campaigns around these issues, the concerns of the PAC may be taken more seriously.

PACs should hold separate meetings with state administrative officials when appropriate. A well-working PAC will be relied upon by state officials when making decisions. For example, during the design of requests for proposals for managed-care contracts, state officials should meet with selected PAC members to review their concerns. The broad-based nature of the PAC will be helpful to administrative officials who will want to prove that they have shared the decision-making process with stakeholder groups across the state.

Challenge #8 - Dealing with political and administrative changes
What happens when a new governor brings with him or her an entirely new administration? Could PAC members be replaced with those seen as loyal to the new political power? Could a well-working PAC suddenly find its recommendations ignored and itself cut out of the political process? Unfortunately, the answer is yes, and PACs must be careful to diplomatically develop new relationships when administrations change.

Strategies
Planning and Advisory Council experts unanimously agree that the best response to political change is to meet with new players as soon as possible and bring them into the cause. This includes inviting new leadership to PAC meetings or orientation events, hosting separate meetings with selected PAC staff and new officials, and other activities that inform new leaders of PAC mandates and their key role in influencing mental health decisions. In one state, the PAC contacted the new governor to inform him of

their mandated role in the recruitment of candidates for the position of director of mental health and then developed a relationship through which they could offer advice on the final selection.

Challenge #9 - Affecting state legislative agendas
Although many PACs are focused on administrative decisions, significant decisions are often made by the state legislature. State legislatures will often have no knowledge of PAC activities or their mandate to monitor statewide services; they may perceive the PAC simply as one of many advocacy constituencies attempting to affect policy.

Strategies
The key to addressing legislative issues rests on two things: relationships and a specific legislative agenda. Just as meetings are scheduled with key administrative officials, meetings should be set up with heads of committees and other legislators who can impact mental health services. To avoid the appearance of lobbying, meetings should be seen as opportunities to share the recommendations of this broad-based council. Legislative lobbying should be left to the individual mental health advocacy groups, who will typically work through a separate advocacy coalition. However, PAC findings and analyses can be presented to legislative bodies as part of their public education mission.

As the new year begins, each PAC should examine its agenda and make very specific goals related to the legislature. Whereas administrative officials may be interested in a year-long give-and-take over a range of substantive issues, legislators may only be interested in specific action items, budgets and legislative proposals. For example, if the PAC has been monitoring managed-care contracts, they likely will develop a list of specific concerns on areas such as consumer rights and protections. In 2000 and 2001, many states will be developing consumer rights legislation to address trends in managed care. It would make sense for the PAC to schedule meetings with the lead sponsors of such legislation and key committees, to offer testimony at hearings and to present papers to full committees. In addition, when the agendas of the PAC match legislative calendars, key legislators and their staff could be invited to present at PAC meetings and to meet with the PAC to hear the insights of various stakeholder groups.

Just as in building relationships with state administrators, one of the keys to strong relationships with legislators is their perception of the PAC as a resource. If the PAC functions as the federally mandated council that brings together all mental health stakeholder groups to monitor and evaluate services and build consensus, legislators will want to work with the PAC in crafting legislative proposals and developing budgets.

Challenge # 10 - Effectively monitoring state plans and mental health systems (beyond the community mental health block grant)
Planning and Advisory Councils are federally mandated to go beyond the community mental health block grant and to evaluate mental health services throughout the state. Unfortunately, this aspect of PAC activity is often overlooked. State officials may view the PAC as an entity to keep informed of changes in block grant funding and even carefully evaluate their recommendations concerning these changes. However, these same officials may ignore the PAC when it comes to community mental health services funded outside of the block grant or new areas of concern such as managed care and juvenile justice.

Strategies
The first step to address this challenge is to make certain that all parties are fully aware of the federal mandates for the PAC that come along with a state's acceptance of block grant funding. This knowledge should be made a part of PAC orientation, be part of meetings with state officials and even be reiterated on correspondence that carries PAC recommendations.

Once this mandate is understood, PACs should work with state officials to develop a strategic plan for oversight activities. Again, these activities should be structured around a specific agenda. For example, PAC members could be involved in state monitoring activities of managed care contracts and use its meetings or other events, such as town hall meetings or focus groups, to learn how changes in service delivery are affecting consumers. Councils also could engage in evaluations of juvenile justice systems to ascertain the number of minors in the systems with mental health needs and the level of services that are being provided. The PAC also could be invited to participate with the state mental health authority as it conducts monitoring visits to the providers of mental health services.

Resources

With the understanding that this document is merely the starting point for the collection and dissemination of exemplary practices in PAC organizing, the following pages contain information on contacting sources of peer technical assistance and model documents for use within your council.

Peer Technical Assistance Contact Information

NAMHPAC
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
P (703) 797-2595
F (703) 684-5968
www.namhpac.org
E-mail: Judy@namhpac.org
Contact: Judy Stange

Rene Anderson
Dept. of Child & Family Studies
Florida Mental Health Institute, USF
13301Bruce B. Downs Blvd.
Tampa. FL 33612-3899
P (813) 974-2199
F (813) 974-7376
E-mail: randerso@fmhi.usf.edu

James McNulty
PO Box 28
485 Main Street
Pascong, RI 02859
P (401) 965-8450
F (810) 821-8137
E-mail: jmcnulty@nami.org

Debra Johnson
Prairie Harvest Human
Services Foundation
930 N. 3rd Street
Grand Forks, ND 58203
P (701) 795-9143
F (701) 772-5560
E-mail: djohnsonphf@yahoo.com

Bonnie Pate
Executive Director, SC SHARE
427 Meeting Street
West Columbia, SC 29169
P (803) 739-5712
F (803) 917-7181
E-mail: bonnie@scshare.com

Linda Hatzenbuehler, Ph.D.
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Idaho State University
P.O. Box 8090
Pocatello, ID 83209
P (208) 282-3992
F (208) 282-4645
E-mail: hatzlind@isu.edu

Joseph de Raismes, J.D., Past Chair
15, avenue du Colonel Bonnet
75016 Paris, France
E-mail: deraismesj@noos.fr

Mike Halligan, MS, Co-Chair
Executive Director, Texas Mental Health Consumers
7701 North Lamar, Suite 501
Austin, TX 78752
P (512) 451-3191
F (512) 451-8302
E-mail: mike_halligan@tmhc.org

Gloria Walker
Chief Operating Officer, Owner
GW Consulting & Education Services
621 E. Mehring Way, #400
Cincinnati, OH 45202
P (513) 651-4485
F (513) 651-4971
E-mail: gwconsultingandeducation@earthlink.net

Mignon Waterman
530 Hazelgreen Ct.
Helena, MT 59601
P (406) 442-8648
E-mail: mrwaterman1@juno.com

Organizational Contacts

NAMHPAC
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(P) 703.797.2595
(F) 703.684.5968
Email: judy@namhpac.org
Homepage: www.namhpac.org

National Technical Assistance Center for State Mental Health Planning
NASMHPD
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(P) 703.739.9333
(F) 703.548.9517
Homepage:www.nasmhpd.org

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration
Knowledge Exchange Network (KEN)
P.O. Box 42490
Washington, DC 20015
1.800.789.CMHS
Email: ken@mentalhealth.org
Homepage: www.mentalhealth.org

NAMI
Colonial Plaza Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(P) 703.524.7600
(F) 703.524.9094
Homepage: www.nami.org

National Mental Health Association's
Consumer/Supporter Technical Assistance Center
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(P) 703.684.7722
(F) 703.684.5968
Homepage: www.nmha.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
Alexandria, VA 22314
(P) 703.684.7710
(F) 703.836.1040
Homepage: www.ffcmh.org

Sample Documents

1. Bylaws

Many planning councils have developed bylaws that describe the purpose, work, structure and accountabilities of the planning council. NAMHPAC staff has collected bylaws from a number of planning councils, and these may be helpful to you for comparison's sake. Contact NAMHPAC at 703.838.7522 to request copies of bylaws from other planning councils.

The following sample bylaws are based on the bylaws of an actual planning council. They are meant to illustrate one approach to organizing and structuring your bylaws. They are provided for informational purposes only and are not meant to be prescriptive for other planning councils.

BYLAWS OF THE [insert state name] MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

ARTICLE I - NAME

The name of this unincorporated association shall be the [Insert State Name] Mental Health Planning and Advisory Council (hereafter the "Council").

ARTICLE II - PURPOSE

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning; (2) to write and/or amend the Federal Mental Health Services Block Grant plan for mental health services in the state of [Insert state name] and recommend such plans to the [Insert State Name] state government; (3) to advise the [Insert State Name] state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof; (4) to monitor, review and evaluate the allocation and adequacy of mental health services in [insert state name] and to advise the [insert state name] state government concerning the need for and quality of services and programs for persons with mental illness in the state; and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

ARTICLE III - MEMBERSHIP

Section 1. Qualification

Council membership composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent federal regulation. Status as a "provider" of mental health services shall be determined by the Council, upon recommendation by the Nominating/Membership Committee. Such determination shall be made upon recommendation of appointment by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as or for a provider of mental health services.

a. Individuals who spend ___% or more of paid time providing mental health services shall be considered providers.

b. Volunteers and advisory and governing board members shall not be considered providers solely because of such status.

c. Under general ethical principles, members of the Council shall recuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

Section 2. Appointment

Membership shall be by appointment of the governor or the executive director of the [insert state name] Department of Human Services (_____) or designee. From time to time the Council may recommend appointment of new members or removal of existing members. Failure of the appointing authority or designee to veto such recommendations within thirty days of mailing shall constitute approval of the recommendation.

Section 3. Meetings
Regular meetings of the Council shall be held on [insert day, time and location, e.g.: the second Friday of each month from 9:00 a.m. to 12:00 noon at the Fort Logan Mental Health Institute], unless changed by the Council or the chair. Special meetings of the Council may be called at any time by the chair or by any (_____) members.

Section 4. Notice
The call for regular or special meetings of the Council shall be published by mailing an agenda to all of the members at least seven days prior to any such meeting and not more than 60 days prior to any such meeting.

Section 5. Quorum
A quorum of the Council shall exist if (___)% or more of the total members as of the day prior to the meeting are present. A majority (___)% of the members present is required for any action of the Council.

Section 6. Powers
The Council shall have all the powers vested in it by virtue of these bylaws, together with any other reasonable and necessary powers to carry out the purposes of the Council. The Council may commit itself, but not the state of _____ or any member, concerning any matter within the purpose of the Council.

Section 7. Open Meetings
All meetings of the Council shall be open to the public. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council. Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Section 8. Alternates; Abstention
There shall be no proxies for meetings of the Council. However, state employees and members of advocacy organizations who are designated as members by virtue of their office or advocacy organization representation may appoint a designated alternate to attend meetings in their stead, and such alternate may cast a vote upon presentation of a written appointment signed by the member. No Council member may abstain in any matter not involving a conflict of interest for that member, and all non-voting members who do not declare a conflict shall be counted as affirmative votes.

Section 9. Rules of Order
In all procedural matters not governed by these bylaws, the Council shall be bound by the provisions of *Robert's Rules of Order, Newly Revised* (1990). However, the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these bylaws or of *Robert's Rules* at any time, whether or not such suspension is on the call.

Section 10. Amendment of Bylaws
These bylaws may be amended by the Council at any time, provided that any such potential amendment is noticed as provided in Section III. 4 above, ordered published by a majority of a quorum of the Council, published in final form by a notice as provided in Section III. 4 above, and approved by a majority of a quorum of the Council present at a meeting held after publication in final form, without any substantive amendment.

Section 11. Compensation
The members of the Council shall serve without pay, but the Council may authorize or recommend the payment of reasonable and necessary expenses incurred by members in the performance of their duties.

ARTICLE IV - OFFICERS

Section 1. Fiscal Year; Terms
The Council shall use the same fiscal year as the state. The officers of the Council shall consist of a Chair, who shall be, [elected by the council, appointed by the Executive Director of the [Insert State Name] Department of Human Services, the Governor, etc.] or designee from a list of three nominees presented by the Council, and a Vice Chair, who shall be elected by the members at the first meeting of the Council following the appointment of a Chair. Each officer shall serve for two years or until such person ceases to be qualified to serve as an officer. Each officer shall hold office until his or her successor shall have been duly appointed or elected, as set forth above.

Section 2. Nominations
Nominations for positions as officers may be made by: (a) submitting an application to the Nominating Committee appointed by the Council which reviews applications and makes recommendations to the Council for three nominees for the position of Chair and for at least one nominee for the position of Vice Chair; or (b) nominations from the floor. Nominees receiving a majority vote for the available vacancies shall be declared nominated or elected, as set forth in Section 1, above. Cumulative voting shall not be permitted for either nomination or election of officers. The low vote getter, plus ties, shall be eliminated at each round of voting until two nominees remain for each position for which a nomination or election is required. Each position, including each of the three nominees for the post of Chair, shall be voted on separately.

Section 3. Duties of Chair
The Chair shall be the parliamentary chair of the Council. It shall be the duty of the Chair to preside over all meetings of the Council, and, subject to the control of the Council, to supervise and control all of the business affairs of the Council. The Chair shall be an ex-officio member of all committees. The Chair shall see that all motions and resolutions of the Council are carried into effect.

Section 4. Removal
An officer may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer's position as a member. Any officer may resign at any time by giving written notice to the Council. Removal may occur only at a properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed.

Section 5. Vacancy
A vacancy shall exist whenever an officer is removed, resigns, dies, or ceases to be a member of the Council. A vacancy in the office of Chair shall be filled by the Executive Director of the [Insert State Name] Department of Human Services or designee for the remainder of the term, using the same procedure set forth in Sections 1 and 2 above. A vacancy in the office of Vice Chair shall be filled by the Council for the remainder of the term.

Section 6. Agenda; Executive Committee
After consultation with the vice chair, the immediate past chair, and the director of mental health services of the state of [Insert State Name], to the extent feasible, the chair shall set the agenda for meetings of the Council and recommend action to the Council. Upon delegation by a majority of a quorum of the Council at a properly called meeting of the Council, including authorization of action on any matter otherwise properly before the Council, to the extent limited by such authorization, the chair, the vice chair and the immediate past chair of the Council may be constituted as an executive committee to make any other decision concerning the affairs of the Council in the interim between properly called meetings of the Council.

Section 7. Duties of Vice Chair
The vice chair shall, in the absence or disability of the chair, perform the duties and exercise the powers of the chair, and shall perform such other duties as the Council shall prescribe.

ARTICLE V - COMMITTEES

Section 1. Appointments
Except for the Nominating Committee, the chair, in consultation with the Council, shall appoint all chairs and members of all committees of the Council. The Nominating Committee shall be appointed by the Council.

Section 2. Standing Committees
The standing committees shall be as follows:

(a) *Nominating/Membership/Bylaws Committee*: This committee shall be responsible for receiving and reviewing applications and nominating members to be members and officers of the Council. This committee shall include at least five members.

(b) *Mental Health Resources Group*: This committee shall be responsible for budgetary advocacy on behalf of the Council.

(c) *Planning Committee*: This committee shall be responsible for drafting working papers with the Department of Mental Health in the development of the mental health services block grant plan. This committee will also coordinate the council's review and comment on the state plan.

(d) *Legislative/Regulatory Committee*: This committee shall be responsible for reviewing and recommending to the Council positions on legislative and regulatory changes affecting mental health.

(e) *Children's Committee*: This committee shall be responsible for coordinating information about children's mental health issues.

(f) *Capitation Committee*: This committee shall be responsible for coordinating information about capitation and managed care for mental health services.

(g) *Others as Determined by the Council*: Older adults, hospital based services, etc.

Section 3. Powers
The committees shall have the power and authority to make decisions only as may be specifically assigned by a majority of a quorum of the Council at a properly called meeting of the Council. Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.

Section 4. Other Committees
Other committees may be appointed by the chair as the Council shall from time to time deem necessary or expedient to carry on the business of the Council. The members are encouraged to suggest and to serve on committees in order to further the activities of the Council.

Section 5. Removal
The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE VI - ANTI-DISCRIMINATION

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

Approved by the [insert state name]
Mental Health Planning
and Advisory Council

Date:

Signed by the members:

_____	_____
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_____	_____

Approved:

_____
Executive Director
[insert state name] Dept. of Human Services·

POLICIES AND PROCEDURES OF THE [insert state name] MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

[insert effective date]

(1) [Insert chair's name] will facilitate meetings of the Council from [insert term].

(2) The agenda will be timed and, absent a motion to the contrary, the Council will stick to the agenda, within the limits set by the chair for the conclusion of debate. [insert designee's name] will keep time and let [the chair] know when each time segment has expired, unless and until s/he can find a replacement.

(3) Name tags will be available, and Council members will make an effort to wear them at all times, so that Council members can better get to know one another's names.

(4) The final agenda will be set, as provided in the bylaws, by the Executive Committee. Executive Committee decisions will be made when the agenda is mailed, in order to take into account the developments that require space on the agenda. However, the entire Council will become more involved in agenda discussions by scheduling these after the break. This will allow all Council members to participate in the agenda discussions. If a Council member wishes to put an item on the agenda, it should be presented in writing to the chair before the meeting, if possible. Alternatively, it can be brought up in the agenda discussion. It is the aim of the Council to fulfill its statutory mission by bringing diverse agenda items to the Council and avoiding repeated debates on the same issue, while giving Council members the right to comment and debate on new developments. The Executive Committee ultimately sets priorities, after hearing from the Council.

(5) As provided in the bylaws, committee assignments and chair designations are made by the chair. However, committee appointments are open to all members of the Council who are interested, subject to the chair's need to balance committees and assignments, and all committee meetings are open meetings. The chair will make available some time at the July [time designation OK?] meeting to go over committee and committee chair assignments, and all Council members are urged to participate in committee work whenever possible. If Council members wish to sign up to receive notice of meetings of a committee even though they cannot be regular attendees, they should sign up in a separate category.

(6) There will be no handbook. Instead, it is urged that Council members consult this document and the attached bylaws for the basic structure of the Mental Health Planning and Advisory Council. An orientation packet will be prepared by staff by September [time designation OK?], and orientation will then be scheduled for all Council members who are interested. At a minimum, Council members should become familiar with the strategic plan approved by the Council and the department in 1997 [date OK?], the structure of the department, the budget of the department and the Mental Health Services Unit, the 1997 audit and department's response, and the most recent Medicaid capitation request for proposals. But it is impractical to duplicate all of these documents for every new Council member.

(7) "Soap-box" time will be scheduled after agenda setting, just after the break. The tentative plan is to schedule a ten-minute period for soap-box time, with a (roughly) one-minute time limit per speaker. This would also be the time for making announcements.

(8) The Council is formed under and required to execute the duties provided under the federal mental health planning law, PL99-660, now codified as PL102-321. This law has been in the process of revision for several years, and most recently was revised administratively by combining the twelve original plan categories into five new categories and by greatly simplifying the annual mental health plan format. The law requires that the Council advise the state executive branch on the annual mental health plan, the submission and implementation of which is a condition of the federal mental health block grant. Because the plan must be fully implemented within the plan time period (now stretched from one to three years), it is not a true strategic plan. In fact, the Council recently completed its first true effort at a strategic plan, largely in response to dissatisfaction at the lack of a strategic or forward looking focus in the block grant planning process. The other federal mandate is

for ongoing review of the mental health system, which requires significant monitoring through the efforts of the committees and the agenda items brought before the Council, particularly reports from mental health services.

(9) The basic structure of the Council is that members are appointed by the Council by consent of the director of the Department of Human Services, and a chair is appointed by the director from three nominees made by the Council. The Council thereafter appoints its own co-chair, who serves as a stand-in for the chair. The role of the chair or the co-chair is to serve as the parliamentary leader of the Council. Thus, the chair's job is to help set agendas and to run the meetings, subject to the power of the Council to overrule the chair by an appropriate motion. The chair's principal job in running the Council is to assure that all viewpoints are heard and that decisions are made expeditiously, without Council members feeling either rushed or disenfranchised. The committee structure is essential to this aim, because it allows for more discussion than can occur at a general Council meeting. Persons who are not members of the Council may serve on committees, if the chair finds that they have significant expertise that would not otherwise be represented on the committee. Committee membership and leadership is subject to change whenever a new chair takes office or at the pleasure of the chair in the interim. The aim is to assure a balance of points of view on each committee and to deal with imbalances and other difficulties whenever they occur.

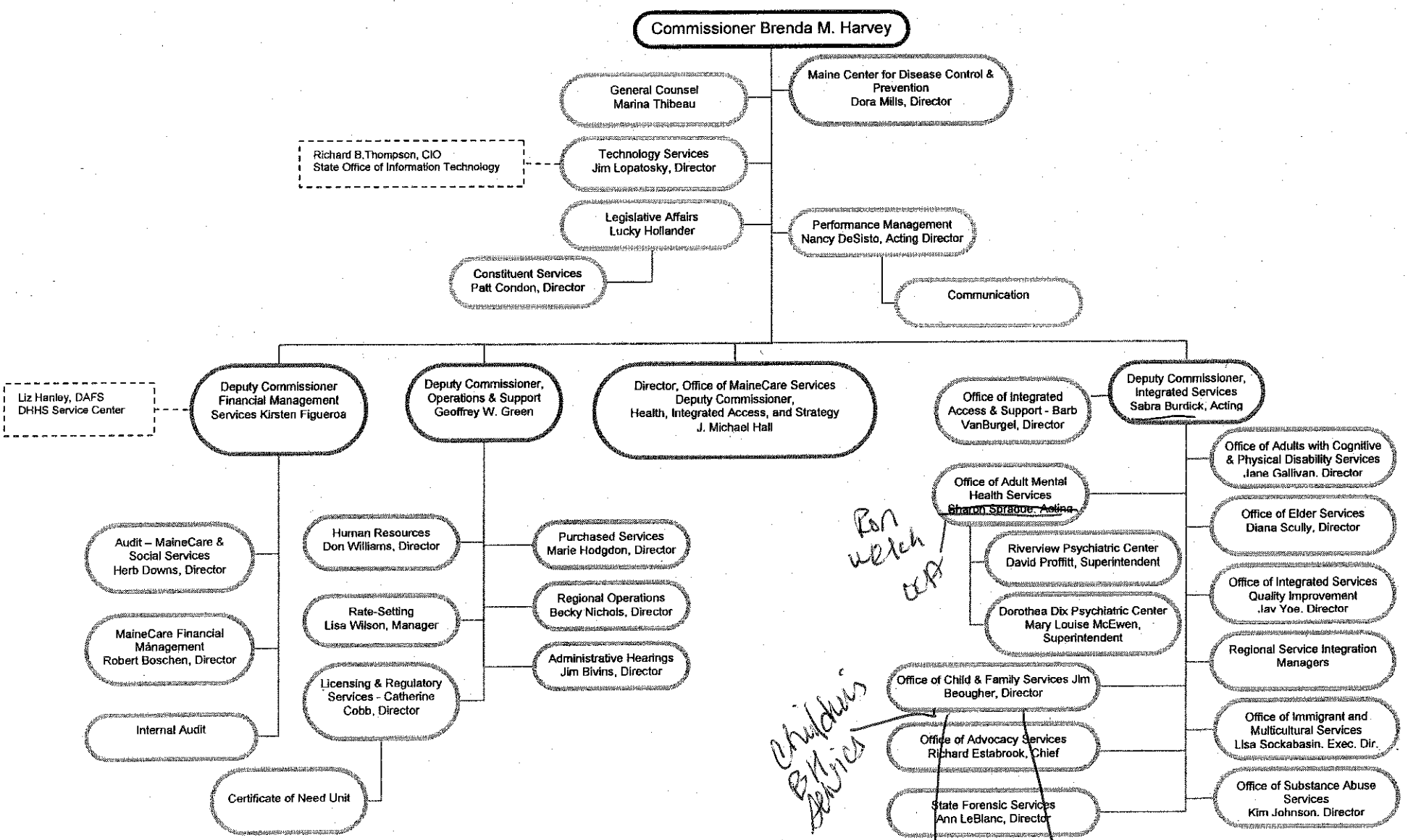
(10) The current committee structure includes an Executive Committee, which consists of : the chair, co-chair, and immediate past chair of the Council, a Planning Committee, a Resources Committee, a Membership and Bylaws Committee, a Resources Committee, a Medicaid Capitation Committee, a Children's Committee, an Older Adults Committee, a Diversity Committee and a Legislative Committee. The committee structure is quite fluid, and new committees can be appointed at the election of the Council at any time.

(11) Although it would be possible to formulate additional policies and procedures, it is the view of the Executive Committee that more rules in the end make for more inflexibility and a less functional organization. Accordingly, whereas a number of rules have been established, as set forth above, it seems unnecessary and unproductive to create additional policies and procedures. Instead, it seems appropriate to make rules only when they are needed. If the foregoing rules are not adequate to put the Council on a track satisfactory to all of the members, this should become apparent by the December [date designation OK?] meeting, when it is intended that the Council's progress be re-evaluated. Accordingly, the Executive Committee suggests that the Council resolve to consider additional policies and procedures after these have been given an adequate trial.

Attachment: Bylaws (restated and amended through this date)

DHHS OVERVIEW

Maine Department of Health and Human Services – revised 05/03/2006



Maine Department of Health and Human Services
Governing Principles

Vision

Maine people live safe, healthy, and productive lives

Mission

Provide integrated health and human services to the people of Maine to assist individuals in meeting their needs, while respecting the rights and preferences of the individual and family, within available resources.

Foundational Values

Honesty, Respect, Integrity, Responsibility, Accountability, Compassion, Empathy.

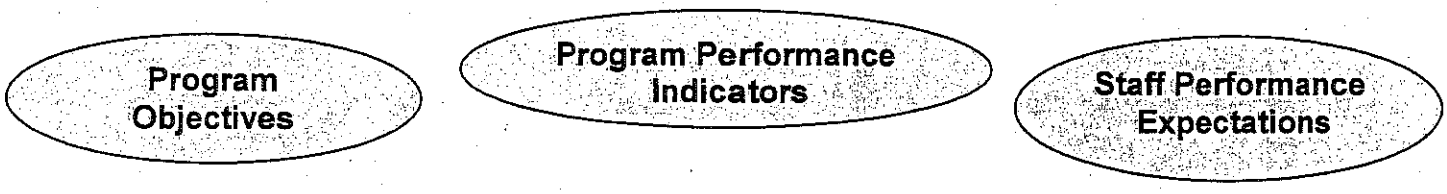
Guiding Principles

- Treat consumers with dignity and respect
- Deliver services that are individualized, family-centered, easily accessible, preventative, independence-oriented, interdisciplinary, collaborative, evidence-based and consistent with best and promising practices.
- Value and support departmental staff as a critical connection to the consumer.
- Engage staff, stakeholders, providers and customers in a collaborative partnership that continuously seeks excellence in service design and delivery.
- Balance centralized accountability with regional flexibility.
- Align systems, actions, and values toward a common vision.

Department Goals

- Protect and enhance the health and well-being of Maine people
- Promote independence and self sufficiency
- Protect and care for those who are unable to care for themselves
- Provide effective stewardship for the resources entrusted to the department

ADULT MH SERVICES



Adult Mental Health Services

Office of Adult Mental Health Services: Draft Outcome Objectives and Performance Indicators

The Office of Adult Mental Health Services has developed four outcome-oriented performance Objectives:

1. **Provide effective and appropriate services to meet the needs of persons with serious mental illness**
   - Increase number of mental health providers offering evidence-based practices for screening and treatment.
   - Increase number and type of Evidence-based services provided (Data Infrastructure Grant-National Outcome Measure: DIG-NOM).
   - Increase percentage of adult mental health service recipients who receive evidence-based treatments (DIG-NOM).
   - Increase percent of mental health providers who provide evidence-based practices that meet fidelity guidelines for service (DIG-NOM).
   - Increase in percent of providers following best practice guidelines for prescribing psychotropic drugs.
   - Decrease rate of re-admissions to state and community psychiatric inpatient facilities within 30 days and 180 days (DIG-NOM).
   - Decrease length of stay in state and community psychiatric inpatient facilities.
   - Increase percent of consumers who report satisfaction with the quality and appropriateness of services received (DIG– Consumer Survey – Quality & Appropriateness Scale).

2. **Support consumer engagement and inclusion in community life, including school, work, housing, social, spiritual & recreational opportunities**
   - Increase percent of consumers report higher degree of community connectedness and belonging (DIG-NOM Consumer Survey – Community Connectedness scale).
   - Increase percent of consumers who are employed in competitive community employment situations (DIG-NOM).
   - Decreased percent of consumers involved with criminal justice system (DIG-NOM).
   - Increase in percent of consumers residing in stable housing situation as measured by reduction in the number changes in stable living arrangements over a 12 month period (DIG-NOM).
   - Increase percent of consumers residing in independent community-based housing alternatives.
   - Increase in percent of consumers who report improvement in well-being outcomes (DIG Consumer Survey – DIG-NOM).

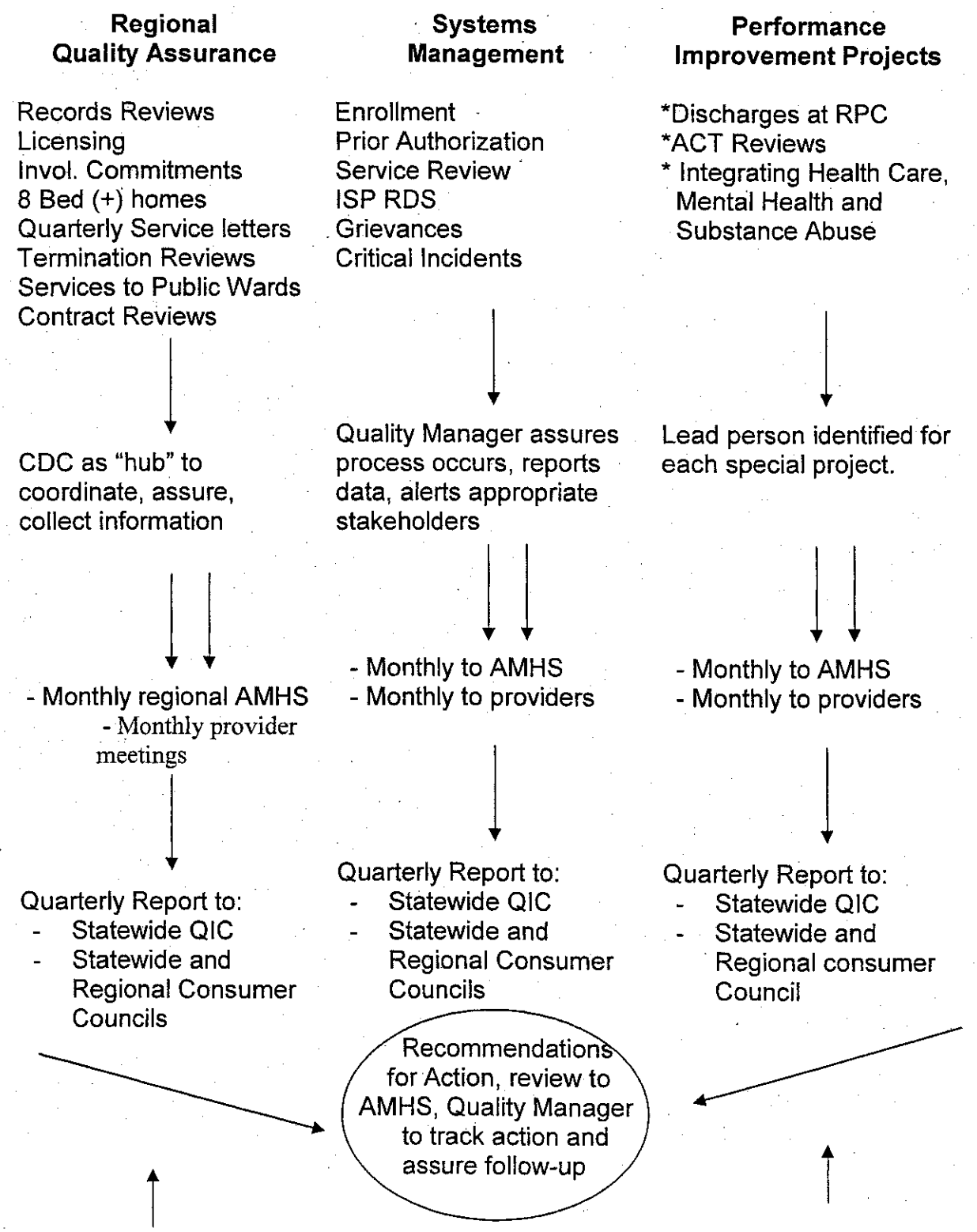
- Increase in percent of consumers who show functional improvement as measured by decrease in LOCUS scores between baseline and annual re-certification (Adult MH Enrollment Information System).

3. **Insure the general health & safety of persons with serious mental illness**
   - Increase quality of medical care, number of persons with primary medical home and quality care for chronic health conditions with adults with SMI
   - Increase in number of health and wellness practices provided in mental health agencies and peer supports. Increase in the number of consumers participating in health & wellness programs.
   - Decrease in the number of critical events.

4. **Promote access to effective & appropriate services and increased continuity of care**
   - Increase percent of consumers who have community provider included in discharge planning from state and community inpatient settings.
   - Increase percent of consumers discharged from a psychiatric inpatient setting who receive at least one face-to-face follow-up contact with a community-based MH provider within 7 day and with 30 days (DIG).
   - Increase use of crisis plans for consumers who have two or more inpatient hospitalizations. Percent of consumers who have been hospitalized two or more times who have a crisis plan.
   - Increase percentage of consumers who receive an appointment with their outpatient medication prescriber within 4 weeks of discharge from impatient psychiatric setting.
   - Increase percentage of consumers who report satisfaction with access to mental health services (DIG Consumer Survey –Access Scale).
   - Increase number of individuals with co-occurring substance abuse and SMI who receive integrated treatment services.
   - Develop additional indicator to capture continuity of care between community-based services.

Adult Mental Health Services

Quality Management Plan



4/26/6

MAINE DEPARTEMNT OF HEAL. AND HUMAN SERVICES
ADULT MENTAL HEALTH EXPENDITURES
FY 2005

SAMPLE Rev 2/2/06

		GRANT		MAINECARE		TOTAL ADULT MENTAL HEALTH	
Adult Mental Health Service	Category	People Served	Grant Expenditures	People Served	MaineCare Expenditures	Total People Served	Total Funded
Social Clubs	Community Interaction	2,465	$ 1,376,596			2,465	1,376,596
Recreation, Social and Lesiure	Community Interaction		$ 96,453			-	96,453
Peer Support	Community Interaction	1,063	$ 179,123			1,063	179,123
Assertive Community Treatment	Community Support	54	$ 184,162	568	$ 6,225,246	622	6,409,408
Intensive Case Management	Community Support			369	$ 2,161,976	369	2,161,976
Intensive Community Integration	Community Support	53	$ 48,806	825	$ 5,803,043	878	5,851,849
Community Integration	Community Support	1,384	$ 2,048,456	9,565	$ 28,897,846	10,949	30,946,302
Daily Living Support	Community Support	15	$ 110,522			15	110,522
Flexible Funds	Community Support	74	$ 703,488			74	703,488
Respite	Community Support		$ 72,988			-	72,988
Skills Training and Development	Community Support	18	$ 31,446	709	$ 11,560,973	727	11,592,419
Warm Lines	Community Support	1,315	$ 173,959			1,315	173,959
Day Treatment Services	Outpatient	60	$ 76,361	656	$ 1,497,441	716	1,573,802
Individual & Group Counseling	Outpatient	4,299	$ 701,148	16,198	$ 16,933,272	20,497	17,634,420
Medication Management	Outpatient	7,329	$ 1,148,276	10,758	$ 8,963,042	18,087	10,111,318
Specialized Direct Services	Outpatient	390	$ 446,904			390	446,904
Specialized Group Services	Outpatient	8	$ 9,325			8	9,325
Crisis	Crisis	11,110	$ 6,790,100	5,901	$ 10,589,274	17,011	17,379,374
Inpatient Psychiatric Hospitalization	Inpatient		$ 485,000	3,102	$ 9,673,776	3,102	10,158,776
Residential Services	Residential	31	$ 4,004,684	748	$ 30,620,581	779	34,625,265
Vocational	Vocational		$ 938,890			-	938,890
Mediation, Advocacy, Interpreting	Mediation, Advocacy, Interpreting		$ 95,709			-	95,709
Rent Subsidies	Rent Subsidies	263	$ 3,503,213			263	3,503,213
Transportation	Transportation	937	$ 368,832			937	368,832
QIC	QIC		$ 19,381			-	19,381
Information, Referral	Information, Referral		$ 247,174			-	247,174
Professional Services	Professional Services		$ 593,487			-	593,487
Training, Research, Overhead	Training, Research, Overhead		$ 2,010,537			-	2,010,537
Legal	Legal		$ 430,634			-	430,634
A Safer Place (Baxter)	A Safer Place (Baxter)		$ 285,420			-	285,420
						-	-
TOTAL:		**30,868**	**$ 27,181,074**	**49,399**	**132,926,470**	**80,267**	**160,107,544**

DIG Objectives 2005

Objective 1: Data Collection and Data Capture Tools and Methods

Develop new and refine existing data collection and data capture tools and methods necessary to reliably produce the required Federal URS data tables and performance indicators.

- Develop interim and long-term strategy and implementation plan for capturing complete URS Data on all Medicaid/non-Medicaid clients and service encounters for inclusion in FY2005 Federal Data submission
- Establish agreements/protocols to capture selected URS data from other state departments with an initial focus on piloting data linking and data transfer protocols with the Department of Corrections and Department of Educations.
- Establish agreements and data linking protocols to capture homeless and shelter use data from the Homeless Management Information System (HMIS).
- Develop and implement protocol for direct linkage to State Psychiatric Hospital data systems to capture state psychiatric hospital data elements.

Objective 2: Continued development, implementation and refinement of the data collection methodology for consumer, family and youth surveys.

- Make needed refinements to consumer and family survey tools to capture required National Outcome Measure elements and additional client descriptive data, including: social connectedness, criminal justice data elements and living arrangement.
- Refine and enhance mail survey sampling and data collection methodology
- Develop and test strategies to promote and enhance the use of a Web-Based electronic survey among mental health service recipients.
- Design and implement statewide consumer and family forums/feedback sessions to share survey and URS results, obtain ongoing stakeholder feedback, and provide additional opportunities for consumers and family members to participate in the annual survey, in collaboration with established consumer and family organizations.

Objective 3: Establish Evidence-Based Practices (EBP) Evaluation Mechanism

- Design and test fidelity assessment tools and structured review protocols for use in the evaluation of identified evidence-based practices, including ACT services, Supported Employment, Illness Self-Management/Recovery-Oriented Services, Supported Housing, Multi-Systematic Therapy, etc.
- Implement Adult Mental Health EBP fidelity assessment for Assertive Community Treatment, Supported Employment and Supported Housing Services
- Implement Child/Adolescent EBP fidelity assessments for MST services, Therapeutic Foster Care, Functional Family Therapy, etc.

Objective 4a. Assure Implementation of DIG Data and Reporting Requirements and Processes in the Enterprise Informational System (EIS).

- Incorporate the capacity and functionality of the EIS in DIG planning and implementation of surveys, data collection tools and processes, and reporting.
- Identify and define DIG needs and requirements for incorporating in the EIS, including specification of any needed enhancements to the EIS and/or related processes.

Objective 4b: Develop Automated Standard Ad Hoc Reports of the URS Data

- Design and produce, with ongoing stakeholder input, user-friendly adhoc reports of RUS client profile, service use and outcome information for use in services and system planning.
- Develop and produce a DIG report production and dissemination schedule and publish on DHHS website.
- Design and generate automated reports of Federal URS tables from the EIS using COGNOS report development functions.

Objective 5: Enhance/Expand Stakeholder Engagement and Participation at all Levels of the DIG Project.

- Develop a plan for the ongoing involvement and participation of consumers and family members in all aspects of the project design and implementation, in collabaoration with the DHHS Office of Consumer Affairs, DIG Steering Committee and Block Grant Planning Council
- Develop and implement formal mechanisms for the dissemination and review of DIG data to a broad array of Department stakeholders, including: consumer and family forums/discussions
- Develop and implement strategies to involve consumers and family members in data collection, report preparation, and information dissemination and review activities
- Develop formal communication linkages with statewide consumer and family organizations to facilitate broad-based dissemination of DIG Project updates and expanded review and feedback on mental health system performance data and trends.

Objective 6: Expand and Enhance Information Dissemination and Quality Improvement Review and Feedback Functions.

- Design and implement a formal process for broad, external stakeholder review and feedback around system and service quality issues. The State's Block Grant Planning Council, Quarter Regional Consumer Forums, and the Maine Association of Mental Health Service Providers will serve as primary structures for external review and feedback on DIG service system performance information and trends.
- Expand and refine existing Quality Improvement Review process to enhance participation and involvement of consumers and family members and service providers in the DHHS Quality Improvement review and feedback process.
- Develop capacity for Web-based reporting and dissemination of DIG related quality improvement reports, URS tables, and Project updates.

Objective 7: Quality Improvement Education and Training Initiatives

- In collaboration with consumer, families and service providers, plan and provide presentations on the use and understanding of mental health services data with particular emphasis on URS information

Objective 8: Data Quality Standards and Review Functions

- Review existing data quality review functions and develop and implement data quality standards and review procedures, in collaboration with the DHHS Office of Technology Services
- Establish procedures and implement regular data quality reviews of all generated data reports that involve participation by internal and external project stakeholders

Objective 9: Integration of DIG goals and activites with Departmental and other State integrated information infrastructure and data systems and projects in conjunction with the Office of Technology Services.

- Incorporate the capacity and functionality of the Phase III EIS design in DIG planning for, development of, and implementation of surveys, assessments, data collection tools and processes, and reporting, including access by providers, consumers, and family members.

CHILDREN'S BEHAVIORAL SERVICES